

Dr. Lynn McPherson:

This is Dr. Lynn McPherson. Welcome to Palliative Care Chat, the podcast series brought to you by the online master of science PhD and graduate certificate program in palliative care at the University of Maryland. I am delighted to welcome you to our podcast series titled Founders, Leaders and Futurists in Palliative Care, a series I have recorded with Connie Dahlin, to support coursework in the PhD in palliative care offered by the University of Maryland Baltimore.

Hi, this is Dr. Lynn McPherson and thanks for joining us. We're very excited to be continuing our podcast series and recordings for the PhD program titled Founders, Leaders and Futurists in Palliative Care. As I said, my name is Lynn McPherson. I'm the program director of the PhD MS and a graduate certificate program. I'm delighted to be joined by my friend and colleague, Connie Dahlin who will be teaching in the first course and ironically the last course in the program.

Connie, why don't you take it away and introduce our guest today.

Connie Dahlin:

Great. Welcome everyone. Today we're really honored to have Dr. Joan Teno with us. Joan has been in the field for many years and hopefully as PhD students and researchers you will be coming across Joan's numerous articles that she has written over the years because she's a health services researcher. She has been really thinking on the ground from being a clinician herself thinking about hospice. She started off in Rhode Island and worked with the hospice and palliative care people there and thought about the first toolkit, and she'll explain more of that when she was at Brown.

Then she moved across country and has been in the Northwest and continuing her work. She has worked for CMS. She was on the 2014 Dying in America Report. She has done numerous types of things. We're really grateful to have Joan speak to us because I think as PhD students you will need to understand the research and be able to review it, interpret it and think about what it means for the field.

Thank you, Joan. Do you want to talk a little bit more about how you got here and what kind of kept you in it?

Dr. Joan Teno:

I think life is somewhat serendipity. When I started my residency a very long time ago my first rotation was in the ICU, and then when I was about to leave that rotation the person who was going to take over for me quit the residency program, so they said, "Well, you're on a vacation block, why don't you just get both your ICU months out of the way?" I spent the first nearly 10 weeks of my residency program in the ICU.

Now, there was good news and bad news with that. The bad news was I was in ICU on call every other night. The good news was, Dr. Dan Brock, who was one of the key writers of the President's Commission on Biomedical Ethics was a philosopher who was being paid by the National Academy of Science to round with interns in the ICU. I spent the first 10 weeks of my residency rounding every Monday through Friday with Dan Brock and having discussions about ethical issues. That's what transformed it for me and got me thinking about a lot of these key issues regarding end of life care.

I think two other things really happened. One thing that happened was we managed to empty out the ICU except for one patient who was an endstage dementia patient in septic shock. I spent the night at her bedside just dialing up the pressors to limit where we were going to stop while she died. I thought, this is just... It's terrible. This is not what end of life care should be in the United States with a

total stranger sitting at her bedside dialing up pressors with none of her family around her. I just thought we could do a better job.

Other patients when I became... For two years I was a service attending taking care of indigent patients. That really shaped my desire to improve how we care for seriously ill and dying persons. I was very fortunate to do a geriatric fellowship and then to do a post doc and help service this research with Vince Moore at Brown University.

From there I managed to land a job at a little study called The Support Study, the study to understand prognosis and preferences for outcomes and risks of treatment and was just an unbelievable opportunity of a life. I walked in there as an assistant professor and just learned so much by working with both Bill Canals and JoAnn Land. A lot of the work in the support study informed the next steps of research which I did for the last 25 years. How did that happen?

Connie Dahlin:

When you think about where palliative care was at that point because I think we had discussions with people and they were talking about support was really important for what it may have proved or not proved, but it certainly guided so much in terms of the research and then Robert Wood found some foundation in terms of funding palliative care. What are some of the other thoughts in terms of the importance of support or if we were to repeat that now, would we find the same results or would we do it the same way? What do you think if somebody said, well, that was then. I want to repeat it now because we don't know our environment anymore.

Dr. Joan Teno:

There's a lot to unpack in that question. I think one thing I really want people to know is the support study was a really negative randomized controlled trial. It was a clustered randomized controlled trial with nearly 10,000 patients. For the outcome measures that we chose, it was negative as you could be. There was not one single P value. To the credit of the Robert Wood Johnson Foundation, they said, we can't live like this. We need to invest more money to disseminate the findings of the support study and then to really help fund and create centers for palliative care and fund future projects.

I think a lot of that credit goes to the staff of the Robert Wood Johnson Foundation who invested probably even more money into growing the infrastructure in palliative medicine. A lot of us were able to become professors based on our early involvement either with the support study or with the funding that came after the support study. I think the one thing that I'm always puzzled about is how much can you accomplish in a lifetime. I kind of am at a reflective stage now. Why couldn't I do more? Why didn't I make the bigger change? Why couldn't we have really fundamental change on how to care for seriously ill and dying persons? It gets me trying to reflect about are we doing the right thing. Are we employing the right strategies? Is there something that we need to rethink about how we're financing healthcare?

I think one of the things that I took out of support, and my role in support as a very junior, junior person was I worked with the data safety monitoring board, and they asked me to read every 10th narrative that the nurses wrote who were doing the intervention just to make sure that things were going well, that there wasn't any clinical concerns. What I just was really impressed was how it was the elephant in the room that no one was paying attention to and how people got trapped into this mindset of continuing to do ICU care until really it was futility.

I think I was moved by many of the quotations that were in these narratives written by the support nurses. They talked about how difficult this decision making was. That got me really interested

in really understanding how we make decisions. Then the second thing which seemed to be a driving thing that came out in the narrative is what you pay for is what you get. I became very interested in the intersection of how we measure the quality of care from the perspective of that dying person and those who love and care for him and then how we finance it.

I tried for the last 20-25 years to really try to make contributions in thinking about how we do that by working with a lot of different teams. That's one thing. For those of you who are students out there wanting to pursue this research, teams are the best. I've been very fortunate throughout my entire life to be part of multidisciplinary research teams, which creates a richer product that just makes the science better.

I think the other thing I want to point out as I reflect, there was a cadre of people who I grew up with who we all became assistant professors at the same time, and the one nice thing is we shared, we shared experiences, we shared findings, we helped each other. Because really what was so important to us was trying to be informative and trying to make things better for our patients.

Connie Dahlin:

When you think back are there certain things after support that you think were seminal, that gave you hope that we were making progress?

Dr. Joan Teno:

Yeah, I guess maybe I had very high expectations. I actually think there were things that were huge accomplishments. The real investment in having faculty in palliative medicine in all medical schools was a huge accomplishment. The fact that we have departments or sections of palliative medicine is really huge. When I started my post doc, one of my research projects was looking at the use of advance directives. One of the very famous oncologists said, "Well, that's a nice hobby. Now tell me what you're going to do with your life." I don't think that would happen right now. People will look and say there's a body of evidence about end of life care, about care of the seriously ill and that this is as important for someone to become a professor of medicine in this as someone studying viral infections or trying to create a new vaccine.

That, I think, in itself is a huge accomplishment. I guess naively I kind of hoped that people wouldn't die in pain 30 years later, that the narrative from an article I just published about two months ago where the family member recalls their family writhing in pain on the floor because they weren't getting pain adequately treated would no longer happen. Yet, it still does. I think that's a little bit frustrating to me, and I wish that I wouldn't have to read narratives like that. I wish that even more that that family member would not have that sentinel memory of what happened to their loved one.

In sort of my introspective phase here, I wish we could've made a bigger difference, but I also want to acknowledge that some really huge progress has been made in terms of infrastructure, in terms of having hospital based palliative medicine teams, about the fact that we're finally talking about doing policy changes to deal with the Medicare hospice benefit and trying to get services more upstream for these people, which I think is really important.

I think we're making progress, but am I satisfied? No. Maybe I would never be satisfied unless we really achieved our goal. As I had talked with some of my junior folks, well, the torch is now yours. You really need to take this up because it's going to be a constant pushing to make sure we do better for this very important and unique population.

Connie Dahlin:

Two questions. There's been a little bit of talk recently that advanced care planning is dead. Curious what you think about that comment and that palliative care should be focusing elsewhere. My second question is, with the policy changes we've been sort of talking about it for 40 years. Do you think that it will happen? What do you think that the effect would really have?

Dr. Joan Teno:

Obviously thinking about advanced directive is something I've spent a lot of my early career thinking about. The one thing I've tried to do is to write some summative articles that lay out my thoughts. There is a New England Journal Sounding Board about complex interventions to improve end of life care. My take is advanced care planning is an important aspect, but it's not sufficient. If you take a look at the data from Oregon, and I wrote this paper... Well, Susan Toll was the first author, but it was a joint paper. What we tried to point out was what they didn't work and was just hand out pink sheet. They educated, they changed laws. They looked where barriers were and tried to solve those barriers. Hospices had the capacity now to enroll people from the hospital to go home to die.

There's a series of really complex things that have to come together that will improve end of life care. One of those key things, unfortunately, is financial incentives. Financial incentives can be important to making change, but also can be dangerous to making change because you don't want care to become equilibrated or equal to not providing access to care. This is a very complex time where individuals may vary on what their goals are.

We want to try to support people to be able to, if they choose, reflect on what's important to them and give them the opportunities to have the best quality of life as they define it during this time period. We don't want to oversell that this is all about saving money. Really what should be out front and center is this is about meeting someone in a very sentinel period of time for that person and their family and really trying to improve their quality of life. It's not about dying per se, it's really about living and trying to make sure that they are having the best possible quality of life that you can provide them.

Connie Dahlin:

When you think about that, it's interesting because I think so many people use this advanced care planning as their metric or we have palliative care teams and that's how they start, but they never then grow out to some of the other dimensions. I think when you're speaking to that, I think that the danger also is we have a lot of work to do in palliative care. We have also a lot of health disparities and inequities. When you think about the whole advanced care planning process for some cultures it might not even be culturally appropriate.

So there's this challenge of what we're selling and then trying to make sure access, I guess. I guess the other part of thinking, how do we help kind of shape the future? When you were talking about you get what you pay for, we're trying not to monetize this, and yet we have this hospice benefit, but we don't have a palliative care benefit. Should we? Or does that just make it muckier?

Dr. Joan Teno:

Let me sort of address some of the financial incentives. I've been really fortunate this year in that I've been invited with a new journal JAMA health forum to write a series of essays on end-of-life care. In that first essay that I call, Hell No, I Won't Go, it's about financing. I talk very clearly about my dad's death. I think what we have to realize is there is a significant proportion of people who really want aggressive treatment until a point of futility.

If I had to estimate that population based on work that I've done on contracts, for example, the Medicare Choice Model. In the Medicare Choice Model, it's about one in five people who either die on the Medicare Choice Model Benefit, which is a concurrent care benefit, or they die after a three day hospice stay. I don't think that represents a failure of the hospices to adequately educate them about the benefits of hospice. I think this is their preference.

The same thing with my father, his preferences were very clear. My job as his durable Power of Attorney, was to support and allow him to live a life that respected his goals of care. I think one of the things that we've underestimated is there's a sizable population out there be it 20, maybe 25%, whose preference patterns are only for stopping treatment when it's really futile or the treatment toxicity is too much. Yet, these people still have important unmet needs, so they're not going to make a choice of the Medicare hospice benefit. How can we provide them with services?

I do think there's a lot that palliative medicine can do or palliative care can do to provide services to these people, so we need to have an adequate funding mechanism. Now, my little bit of frustration with how Congress has structured these models of care is they said every model must be cost neutral or save money. Think about it. You're asking for high cost, high needs population to be cost neutral. I think really financing from looking at it from the perspective of a bigger population is really what we really need to do, and we have to realize that when people get really sick it's an expensive part of our life. It's an expensive time of healthcare. To always make the assumption that you're going to save a lot of money, I think, is the wrong assumption, and we should really focus more on quality of life.

Also, I think we also need to think about what are all the downstream implications on what happens to family members when they deal with someone in the ICU and they have a posttraumatic stress disorder or have prolonged grief. I think the right thing to do here is to try to figure out how can we provide services that go upstream that is not breaking the bank here, but allows to get some support and services there, and yet serve the very important role that the Medicare hospice benefit plays in end of life care.

I think we need to really figure out that financing puzzle. Now, the problem with all this is how do we make sure that we're all good citizens? I think it's really important that we have transparency. Not everybody goes into healthcare for the same reasons that many of my colleagues go into palliative care. One of the things I think we had to be very careful about is the incentives that money can play in really reeking havoc on end-of-life care. There's probably a small percentage of hospices out there who are not living up to the ideals of those people who created hospice.

The one study that I did I think that puts some kind of finger around this is we looked at hospices who didn't visit anybody in the last two days of life. It turns out it was about 8% of the hospices who had 30 or more deaths in a year, did not manage to make one visit even by accident in a dying patient at home. I think you've got to work really hard to avoid getting at least one. There are some providers out there who are not living up to the ideals that I would want them to live up to and really focus not only on trying to make sure your profit margin is high, but focusing on caring for patients.

I guess one of my biggest frustrations we've got have actionable measures that allows us to weed out these providers who are not doing a good job whose motives are too much on profit rather than on caring for persons.

Connie Dahlin:

There's two thinking of do you see palliative care programs trying to do that same thing or do you think it'll be solved if we have more of a concurrent model that becomes the norm for adults?

Dr. Joan Teno:

I think concurrent care is a very important option because I think there's a sizable proportion of the population who are not going to buy into the philosophy of the Medicare hospice benefit. But if concurrent care primary measure of success is saving money, then there's going to be a huge problem because people will not have access to needed services. I think we already saw in UK a fairly substantial concern with the Liverpool Pathway. We saw some little spikes here, for example, in a healthcare system who said that everybody had to have a post form at 65 or something really ridiculous like that. And then all of a sudden the Oregon post registry sees a spike in people wanting CPR, and then the problem becomes, well, no one updates those forms, and then what do you do when they have metastatic cancer when no one has updated those forms?

I think we need to provide the right financial incentives but also have the right oversight with accountability measures that are publicly reported to ensure high quality care. We have to go upstream, we have to finance it, but we have to do it in such a way that we're looking for the small number of providers who are not behaving well.

Right now, some of the community based palliative care it's, we don't know. There's a huge for-profit program that goes to MA providers and says, give us \$800 a month, and we'll take on these patients and we'll save you money. Well, it should not only be about taking on these patients and saving money, the next part of that sentence should be, "We will take on these patients. We will provide them with high quality of life, high quality of care, and we will do it in a cost neutral fashion."

I think it's really important as we go upstream that we have these measures. I think the best measures is either speaking to that seriously ill person or speaking to their family to really understand the quality of care and to make sure that people are not being pushed into a choice that they don't want.

Connie Dahlin:

In terms of thinking about, do you think that... We've been hearing that people wanted to look at the Medicare benefit for a long time. I know that we were in, well, we still are, in this whole political part because when you think about what happened with the death panels it took us 10 years to get ACP not equal death panels and pass. I know hospice was a little concerned that if that got opened up given the current bipartisan relationship that it could disappear. What are your thoughts about that moving forward? I think our students would certainly be involved in thinking about some of that policy, and what route do we go?

Dr. Joan Teno:

I think the issue is the same thing that happened in the UK with the Liverpool Pathway. It's very easy for someone to sensationalize this and to rev up people to be fearful. I think especially in our field we need to make sure that we're doing the best possible job. I think it's really important that we have actual transparency measures.

My biggest fear is as we go upstream some large entity is going to be so focused on making a profit that they're going to do something really stupid, and it'll blow up, and then it'll set us backwards. That's one of the reasons why I have spent a lot of my time thinking about how we can measure the quality of care, how we can publicly report it. I guess what's frustrating to me is how can you not have compassion. Some people really look at it from a perspective that this is just money. I can't look at that perspective. This is not just money. This is someone who could be your mother, your brother, your sister

and we need to really not hate them because they have a different skin color or not hate them because they have a horrendous disease that you didn't inherit.

We need to be compassionate to them and provide the help for them faced with these challenges. I get really frustrated when I've been listening to these early books on COVID that there were some people that weren't compassionate. It was not about what was doing right, it was about political gains. The minute we go down this route where it's just all about political gains and power, we're going to lose. We're going to lose our moral center.

Connie Dahlin:

When you think about some of the metrics, I know I've been involved with the National Quality Forum and some of their work groups, and I know you have the CMMRI, how do we kind of bring together some of these ways of reporting quality? We in healthcare sometimes have a sense of how to find it, but I don't think patients and families know at all how to kind of look up difference hospices. I don't think palliative care teams you can even look up. You can't even get a sense of what the quality is, and you find out bit by bit.

My story is that my mother in law lived in Florida. I was trying to get her palliative care because she wasn't hospice appropriate, and somebody said, "Oh, because of who you are, we'll start a trial program." Well, that's not what I want to hear. It was a total fiasco. How do we help families be able to... besides the state organizations hospice locators, which never really give you what you want, how do we help that and really think about that reporting?

Dr. Joan Teno:

We need to invest in making sure that the information that's on hospice compare is actionable to consumers and that consumers can use that information to make choices. I think in the past I've worked on a number of series of questions that a consumer can ask of a hospice program to know if it's a high quality hospice program. I think based on my involvement in CAHPS hospice that the survey tool is discriminating among high quality hospice programs and poor quality hospice programs.

I think maybe part of the frustration is that probably the vast majority of hospice programs are really good. The issue is there's a small percentage. It's like everything we've talked about hospice and palliative medicine it's this weird distribution. There's this distribution where a lot of it is slammed over to this side of the curb and then there's a small portion out here. There's a small portion of hospice programs who I think probably should be closed down, that the quality of care is they're not staffing it right, they're not doing after hour visits. I think there's really a role for making hospice compare transparent and actionable to consumers, but also for certain survey to step up and really start targeting these programs and Congress giving them the authority to close some of them down.

I have a firm belief that stop signs are an important part of our life. We just can't have a society where there're no stop signs. Government needs to play a very important role in helping ensure that there is quality of care. The issue on that role is we don't want to be over regulated, but we want to hit that right balance to make sure that these providers who are just not conforming to the rules and regulations are told either improve or lose your license, lose your ability to admit Medicare patients.

Dr. Lynn McPherson:

Can I ask something? Dr. Teno, do you think that the hospice compare is looking at the right data? For example, it makes me insane when we're trying to use an antipsychotic drug to treat nausea, garden variety nausea in hospice patients; Zyprexa or haloperidol or whatever it may be, and the answer we get

is, no we can't do that because that will affect our star's rating. I just want to poke out both my eyeballs. What do you think about that?

Dr. Joan Teno:

First of all, I think it's most likely nursing homes that are saying that. Like anything else, any quality measure, you've got to get the denominator right. It's got to be the right population, and then the really hard part you have to think about is how some providers are going to game the system. You need to put enough finances in to make sure you have the right denominator and make sure you have enough data edits occurring.

The one thing I'll say is it's a black box out there on how we use some antipsychotics in hospice patients. I had the privilege of working with a really wonderful geropsychiatrist who's opening that black box and asking questions about people who are admitted to hospice with dementia, who end up with a live discharge. What are we doing with them in terms of prescribing antipsychotics? Antipsychotics, like anything, I think everything has to have a risk benefit ratio.

If someone is actively dying, I'm not worried about... the benefits really outweigh the risks. I think you've got to be very careful with some of these diseases where they can really truly have higher risks because they're really not actively dying. That's I guess one of the frustrations of dealing with some of these noncancer and also with dementia is it's a very lingering, slow disease trajectory. It can be hard there. Hold on for a second. Sorry. It just was a text message. It was from one of my dogs at daycare. I just wanted to make sure there was not a problem. I apologize for the interruption. It was just a picture of my dog playing in a mud puddle.

Dr. Lynn McPherson:

Such a palliative care vision, right?

Dr. Joan Teno:

I have a 16 month old puppy who I send to daycare twice a week to blow off steam so the older dogs can have a respite from him.

Dr. Lynn McPherson:

I agree with antipsychotics with delirium and particularly in dementia. I think that's iffy, and I think those are on the way out. We've got good data showing olanzapine for garden variety nausea in palliative care can be quite beneficial, but we get the same pushback on that too. That's disturbing.

Dr. Joan Teno:

Here's one of my frustrations. Since you're mentioning one of your frustrations, I hope you don't mind if I mention one of my frustrations.

Dr. Lynn McPherson:

Not at all.

Dr. Joan Teno:

One of my frustrations is that we're not adequately funding freestanding inpatient hospice units. I really had the privilege for 18 years providing clinical coverage for freestanding hospice inpatient units and for

people with difficult symptom control, they were a godsend. I can remember prior to us having enough beds in a freestanding hospice in patient unit going to someone's home and watching them seize in their home. It was a nightmare. Compare that to getting someone into an inpatient unit where I can use the right medications to control seizures. But the problem is, that there's not the financing to make it a viable business model unless you have a wonderful philanthropy.

That's why if you happen to live on the East Coast or in a rich community you have an inpatient unit, but if you live in an area which doesn't have the philanthropy to support it, you don't have an inpatient unit. I've said multiple times that we need to look at how we're financing these inpatient units because I think there's an access problem to it.

Dr. Lynn McPherson:

Absolutely.

Connie Dahlin:

When you think about for our students who are going to either step into research or step into leading, what are some of the things that you think they should be thinking about or considering as they move into this career that they are obviously invested in by getting a PhD?

Dr. Joan Teno:

Well, first of all, one of my things is, I'm very excited that 25 years ago you could put all of us in a hotel ballroom, and if there's a bomb that went off, you would wipe out all the research community. What's really wonderful now is that there are many people who are interested in this, who are doing innovative work and who are passionate about it. If I could say one thing, is listen to yourself, listen to what your passionate and follow that and be persistent.

I'm someone who applied for every faculty development grant and never got funded. Yet, I managed to somehow keep myself funded with RO1, NIH, CMS, RWJ, various foundation funding for nearly 25 years. I think persistence is really important and being really committed and passionate about what you do is really important.

I think the one thing that I found really helpful was all throughout my career up until about two years ago, I always was doing both clinical care at the bedside and doing the research. The experiences that I had at the bedside so greatly informed the research that I did. So having both of these roles has been invaluable at least to me to give me really what are the important questions.

You know what? A life where you can focus on what you're passionate about and hopefully trying to make things better is really an ultimate gift. The fact that I've been able to somehow be able to, A, do this research, afford a house, pay for my dogs and still travel some has been really the ultimate gift in my life. I think what I'm doing right now is writing a series of essays about financing in palliative care and trying to make sense of where we should go.

Connie Dahlin:

So obviously our students should be reading your essays to come to think about some of that. I think that-

Dr. Joan Teno:

They should be improving and pointing out what I did wrong and making it better-

Connie Dahlin:

All right. Well, [crosstalk 00:41:52].

Dr. Joan Teno:

Because I'm sure there's are some things I've gotten wrong. I think that's what's so important is that we never lose the sense of questioning things. I'll give a little shout out to New York Times. I've always wondered why the goal was at 10,000 steps a day.

Connie Dahlin:

Oh, yeah.

Dr. Joan Teno:

The whole reason for the 10,000 steps was the person who made the pedometer in Japan called it a 10,000 step pedometer. It wasn't based on research. It was only based on a marketing ploy.

Connie Dahlin:

I saw that.

Dr. Joan Teno:

It turns out that some research is 5,000 to 6,000 steps is enough. I think all throughout my career there have been so many things that we've done in medicine because that's why they did it. I during medical school worked as a nurse's aide in CCU. We put all those patients to bed rest. No one would even think of that now. I think question, don't just accept that what you've been told is right, but really think about questioning things and being open to exploring alternative hypotheses and be open to asking these really difficult questions. It's hard to ask questions when everybody says, but, whoa, it's 10,000 steps. Everybody says it's 10,000 steps.

I think you need to really if you do research you have to be open to accepting or rejecting a null hypothesis.

Dr. Lynn McPherson:

You mean the cereal companies may be wrong when they say breakfast is the most important meal of the day?

Dr. Joan Teno:

Let me get in trouble with another constituency.

Connie Dahlin:

I think also you make a point. I think in the process of Lynn and I doing all these interviews, we've sort of had a sense of what people did and kind of balancing and just trying to get things established. Now we're in such a place of, okay, what do we kind of take as this is kind of prestandard and what do we continue to question. We have this whole new generation that as you know has very much different technology, different views, and I think they do need to question.

I think the other part that drives me personally crazy is, and you kind of hinted at it, we are in a very challenging time to change because if you look at a lot of things, particularly in academic medical

centers, when you try to change something, they're like, well, this is the way we've always done it. It's like, okay, but that's not working. How do we change this? So it's not only the mindset of everybody but saying this newer generation that is going to question.

I think the other part is as you named it, I think probably over the past 40 years those of us who were in hospice and palliative care have sort of assumed that there is, and you mentioned this, this compassionate doing it because it's the right moral thing, that all of the palliative people involved in palliative care come from that. I would say that I have learned over the past year in COVID doing a lot of things that we are not all earthy, crunchy that. I think for me personally, for some people, they're like, oh, my goodness, I didn't realize that and what were you thinking.

That also is almost a contradiction to this palliative care is doing the right thing and being compassionate to know that we have a subset that may not have the beliefs of equality or not making money.

Dr. Joan Teno:

There's something about the dichotomy of someone who is a hospice CEO affording a private jet and staffing not being right. You have to decide where you're going to draw your own line, but I find something really abhorrent on someone making 30 to 35 million dollars by starting a for profit company for hospice and selling stock. That just doesn't seem to me the right set of values that I personally want to live by.

Dr. Lynn McPherson:

Well, thank you so much. This has been amazing. You're a lovely person. Thank you for taking the time to talk with us.

Dr. Joan Teno:

By the way, your dog is better than my dog. I have one of them who was squeaking here, so I had to take his squeaker from him to prevent him from squeaking. Your dog all throughout there has been in the background totally asleep. Where can I get one of those?

Dr. Lynn McPherson:

We had company. We had my daughters two dogs for a week, so she's exhausted.

Connie Dahlin:

Also, she's been bored. We've done so many interviews. She kind of knows, okay, here they go again. Anyway, thank you so much. We really appreciate it. I know our students will really appreciate some of the thoughts that you've given for them to think about their research and kind of working and we are in kind of this crossroads of care of next steps. Lynn, any other-

Dr. Joan Teno:

Thank you for your time. I really appreciate it.

Dr. Lynn McPherson:

Thank you. Good luck with the doggies and your travel. Thanks so much.

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I'd like to thank our guest today and Connie Dahlin for the continuing journey in our podcast series titled Founders, Leaders and Futurists in Palliative Care. I'd also like to thank you for listening to the Palliative Care Chat Podcast. This is Dr. Lynn McPherson, and this presentation is copyright 2021 University of Maryland. For more information on our completely online master of science, PhD and graduate certificate program in palliative care or for permission requests regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.