Lynn McPherson:

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

Hello, this is Lynn McPherson and I'm the program director at the University of Maryland Baltimore for the graduate certificate master of science and the PhD in palliative care. This is part of our podcast series on Founders, Leaders and Futurists in Palliative Care. And of course, I'm joined in this activity by Dr. Connie Dahlin, and we're very excited about our guests today aren't we, Connie? Would you like to introduce our guest?

Connie Dahlin:

Yes. I am very thrilled to introduce Dr. Christina Puchalski, who many of you have read about probably in terms of thinking about the spirituality in healthcare, but has been really important in palliative care. She is at the George Washington Institute for Spirituality and Health. Again, you may have heard it as GWish. She has really been pushing this consensus part about spirituality, which we know she'll talk about, and she's also the author of A Time for Listening and Caring, Spirituality and the Care of the Seriously Ill and Dying, which she coauthored with Betty Ferrell. And so, what we're really intrigued about for today is first having you, you can introduce us and tell us more things that you want people to know, but I think at this whole integration because I think we take it for granted of this spirituality place given sort of the religious connotation going way back of hospice, but also knowing that Cicely Saunders was incredibly religious, and just sort of this part about where we are today in bringing that. So welcome, and I'm going to let you start.

Christina Puchalski:

Thank you very much. It's nice to be here with both of you and also congratulations on the program you're developing. I think that's incredibly important as we build further and new leaders in palliative care. It's a great idea. So, where am I with spirituality? Well, just in terms of with palliative care, reflecting on some of the questions that you sent to me, I did start at a time before this was a field. I was very blessed to be assigned, if you will, to Dr. Joanne Lynn and Joan Tino at the Center to Improve Care of the Dying, which was at that time at George Washington University and that was in the nineties. I had just finished my fellowship in primary care and joined the geriatrics division and was already doing a lot of work on spirituality for a number of years.

I started that when I was a medical student and went through with that in residency. And I think they didn't quite know where to put me in, so why not with Dr. Joanne Lynn and Dr. Joan Tino, and that was an amazing place to start. So, I was very privileged to get involved very early on in their work around geriatrics and palliative care and hospice. And as a result was involved in one of the groups with our Robert Wood Johnson Foundation, that was a huge foundation that should be and is often credited, as well as others such as Soros for developing the field of palliative care. And I was involved in a group that actually was interested in spirituality, and we were looking at communication around palliative care, communication around spirituality, why that's important. So, that's just my background in coming into it this way. But I've been interested in spiritual health long before palliative care started being discussed as a field.

I think that spiritual health is an important area of whole person care. You mentioned a book with Betty Ferrell, that was actually Making Healthcare Whole that Betty and I co-edited, and it's based on a work that we did in 2009 in developing consensus guidelines on improving the spiritual domain, the quality of the spiritual domain in palliative care. And that was a very seminal moment, I think, in the field of palliative care in terms of looking at how we should integrate attention to spiritual care and not just physical symptoms and emotional and social symptoms.

So when I started this work in spirituality and health, as I said, it was before the beginning of the field of palliative care, and my interest really was in recognizing that we are more than just physical beings. We have an emotional side, we have a social side, we have a spiritual side, and I felt that this total care model of physical, emotional, social and spiritual, it's really important. And in researching that a little bit more, of course, I came across Dr. Cicely Saunders work on total pain and that concept of the bio-psycho-social spiritual model. So years later, as I to see how I could advance this field of spiritual care, it was only a natural partnership and alliance with palliative care because that already was a required domain in that field, in that evolving field, even before it became a field. So, when we think of what is spirituality, you mentioned religion, or is it spirituality?

Cicely Saunders was religious. I think she also talked about it in a broad sense of the word. We're all spiritual beings. I don't know if you know Jane Goodall, but she was recently awarded the Templeton Prize for her work, and before I went to medical school, I worked at NIH so I got to hear her presentation at the clinical center at NIH, amazing person. And she actually talked about accompanying her chimps through their end of life. So she talked to one chimp that was dying, who was up in the tree and the way she spoke about it afterwards, I talked to her and she was very clear that there's this domain or this essence of life that is in everyone, in animals as well as people. And she has a beautiful description of that in her acceptance speech of this recent Templeton Award.

I like to think of spirituality in that broad transcendent way. Eric Casell talks about transcendence as being deeply spiritual but not necessarily religious. He's a medical ethicist. And I see spirituality in that way, and I think many of us that are in this field look at that inner life. What is it within us? And for some people it may be religious. For other, it may be expressed in relationships or art or music or something that is hard to put words on, which of course it makes it very challenging for those of us that are physicians and like to have things easily defined. But it's not easily defined, but it is, I think, something that is such an essential part of who we are as human beings.

And within the clinical setting, if we have distress in that domain, if you will, spiritual distress, it's significant and it can be incredibly disruptive to a person's life. And so, when we talk about the very nature of palliative care is to be present to others, to take care of their whole care, their bio-psycho-social spiritual model is what it's based on, so to take care of that whole part of the person. We would be remiss in not addressing the spiritual domain, spiritual distress as well as spiritual health.

Connie Dahlin:

It's interesting, because I think as I've been doing some reading just in my practice, it is interesting that we think that's really important and depending on where you are in the country, how we address that is very different. Being in New England it's very different than say in the South. And then, I think this other part, we've interviewed two chaplains and I think this part about understanding how important ritual is, but then understanding that there's this interesting part happening of the number of people who are quote unchurched, and then still the number of people who, if they're in a religious affiliation that that actually makes it harder for them sometimes.

Christina Puchalski:

I'm not quite... what makes it harder for them?

Connie Dahlin:

I think it's Tracy Balboni's work of looking at the people who have a high religiosity, in fact sometimes they can have a harder time with coming to terms with this end of life and trying to make sense of it. So, I just think it's really interesting because you would think about if people are unchurched, well maybe they're adrift and they can't come to terms with it and people with religion would be more comforted, except for then some of the work of if you're more churched, then how do you make sense of it, of kind of conforming to some of the parts? I mean, so it's just interesting and that's probably more theological, but I find all of that just intriguing on a day-to-day basis in practice.

Christina Puchalski:

I think the concept of extrinsic versus intrinsic religiosity may help frame my answer to your question. That we all may, if we happen to be religious, there's an extrinsic aspect of that. Our attendance at faith communities, whether we pray or not, or meditate, and how frequently, those types of more external measures. But how we integrate our understanding of God or religion or our faith is very personal and is very internal. And I think that's what aligns with the spirituality broadly defined area. So, we can get stuck at an identification at a label. We can say, well this person... and this often happens in the miracle discussions... uh-oh, they're religious and the end of life discussion is going to be difficult. What does that mean? So, I think if we try to move beyond that label, if I'm doing a spiritual history and someone tells me that they're Jewish or Muslim or Buddhist or Christian, I certainly want to know what that means to them.

And it's often in that second or third question that it's how do I understand my meaning in my life? How do I understand that vis-a-vis my religion or my cultural background, or what is going on with me right now? So, this is where we need to move into those deeper conversations with people. And that's what's so exciting about how... we have developed a course, Betty and I, on interprofessional spiritual care education curriculum. And part of when I developed that, we were thinking about how do we... we had a module on communication which of course has to do with spiritual history, but I added a module on compassionate presence because when we move into talking around these areas of meaning and purpose, or very, very, very deep suffering, we are not... unlike physical pain management, there's not something that we can quickly fix. Right?

So, we have to be prepared to be present in what may be very uncomfortable for us to listen to, by the way, and resist our very nature to try to make people better, because there's nothing wrong with trying to make people better, but in those areas, those deeply personal areas, the best thing we can do is to be silent and intently silent and really present to someone and listen to their story, and then maybe using some skills around contemplative listening, maybe ask something that might help the person deepen their story but not ours. It's not an agenda driven part. And this is, I think, where those types of questions around how do religious people or non-religious people understand, I don't want to say it's irrelevant, it's not a relevant, but the story often is on a very, very, very deeper level.

And that's where I think we want to be with our patients. It's also about letting people know that we're there during their time of deepest angst, as well as joy. But that, I think, is what's so incredibly important about interprofessional spiritual care and how we, all of us on the team, practice that art of deep listening and presence. We should recognize how to identify and diagnose spiritual distress. And then as you mentioned, working with chaplains as the experts in that area is critically important.

Connie Dahlin:

That's an interesting thing, because I think I've been focused in the last day or so of this difference between communication skills and a clinical encounter. And I think you have to be a clinician to kind of understand that difference. But I think what you speak to Dr. Puchalski, is this part about being present and really that means also some emotional intelligence, right? That somebody says something, we explore it and we go forward, but it may not be a set script. And I find that is an interesting place right now, particularly with COVID, because I think with urgency we needed to teach people some skillsets.

So, we gave them some rules, right? And that's okay for like basic level, but that doesn't translate to some of the more complexity, which I'm trying to have this conversation with somebody about what we're really trying to teach and you are even mentioning it more, is emotional intelligence, but even this spirituality intelligence, right, of that we may not fix it and we might just be present in that difficult time. I still think a lot of palliative care clinicians don't know how to sit in that space.

Christina Puchalski:

As you're talking, I was reflecting on the questions you had about the beginning of this field, where we are now and what are the challenges. So I will tell you, and I think it's what I heard you say, that we equipped people, so for example, the FICA tool is a way to talk about spirituality, but hopefully you integrate that. One integrates that into the way they talk with patients so they don't all of a sudden say, "Whoops, I've got to stop talking about this and now I'm going to talk about spirituality," but it should be a seamless flowing conversation. Right? And what I think of as the strength of palliative care, and I've said this from the beginning, and I don't know that it's a totally popular way to say it, but I think it's just good care in general.

It's a model of the way that people older than us have practiced medicine back in the day where you have a relationship with your patient for whatever period of time. If it's 15 minutes, if it's an hour, if it's 10 years. Now, I have patients that I've seen for many, many years and I have patients that I've just met today and I'm going to begin the relationship today. But, you really sit in a space with that other person for whatever time and while you may have some communication skills that you've learned, it's not that you pull out of your head or on a chart, "Oh, now I've got to ask these questions," but you have to follow your patient's lead. So, you're in a conversation and they may bring up something that sounds like spiritual distress or emotional distress.

And then you know what kind of questions to ask to explore that further. But, what I would hope for palliative care is that we move beyond some of these... we're in a struggle right now because we have to have metrics and things like that that show the efficacy of what we're doing, and that's important, but I hope we move beyond that to just recognizing the importance of the whole person care, the relationship, sitting in front of another together in uncertainty, which was a huge lesson last year with COVID, is again right now with COVID. But how do we sit with another in uncertainty and try to tease out together what are the main issues that we need to address in that particular visit? Right?

Lynn McPherson:

Connie, you're muted. You're still muted.

Connie Dahlin:

I did it too fast, sorry. You brought up something that I think is also really interesting. And it's this part that we know, what is this deep level of assessment and really trying to figure out where the patient is, and then having metrics that don't capture that, and to the next level having administrators who

sometimes may say they value that but then when we do it, they're like, "Why are you spending so much time?" Right? This whole thing about our views. And I find that fascinating. So, I just would love to hear your conversations that you've had with your administration knowing that they know you're the expert on this and that this is such an important part of our care.

Christina Puchalski:

I don't have a quick answer on that because it's a work in progress. I think you have to think about the various stakeholders in these conversations, right? So there's the administration that's going to be looking at dollars, which we can't be doing everything for free, I understand that completely. So, how do we frame, and CAPC and Diane Meier and others have done an incredible job of framing what palliative care does in a way that also speaks to all those audiences. So, you don't need to recreate the wheel, but in terms of spiritual care we're at that point right now, trying to frame those conversations. I don't have exact answers. Certainly, patient satisfaction and alleviating... if we can show that our interventions alleviate suffering, that's crucial. And if we can show the efficacy of each member on the team in doing this, I think that's important, but where we are right now in spiritual care is sort of where palliative care was many years ago. We're at that point of developing demonstration projects in this area.

And what does that look like? And having more and more people involved. When I started this, very few people were involved in spiritual care. And now there's people all over the world that are doing things. So, let's begin to think about demonstration projects or piloting some of these ideas and seeing where that goes in terms of models that people can use in palliative care and clinical practice. I will say to broaden this, that spiritual care is not just within palliative care, it's within all of care. So, I'm working with a colleague, she took our ISPEC course last year, and she's going like gangbusters at Columbia and looking at spiritual care within primary care. One of my thoughts when there's a question about what do I think the future holds for palliative care, honestly, if we are super successful at the generalist palliative care... why did palliative care start?

There are many reasons, but the support study was clearly one of them, people dying in pain and not having their goals of care addressed or anything around that. So, I think palliative care has been incredibly successful in both of those points. And so now, what if palliative care really becomes successful? And we trained generalists and pain is well managed, other symptoms are managed, everybody's addressing the important issues including the spiritual issues, that would be ultimately success. Right? Spiritual distress is attended to, emotional distress, social, physical pain, all of that is addressed, those are really the goals of palliative care. And that all clinicians are able to navigate those conversations around end of life care, around goals of care. And they're messy conversations, right? We're still at a point where I think we're not always integrating spiritual and religious beliefs and values into those conversations, by the way, the goals of care conversations, but we're getting better at it, I think, as a society, but we have a long way to go.

I think once we get to that point and as we succeed, will palliative care be obsolete because we've been able to train everyone? And I'm being very Pollyanna because I think there'll always be a need for palliative care, but I'm just trying to drive the point home of what is the reason that palliative care got started. We have addressed many of those issues. One of the still to be addressed better is spiritual distress. We all have to work on that. And to your point, yes, we need more research and we need more metrics around that so that all those audiences can recognize what we already know is important.

Lynn McPherson:

Do you think we're doing an adequate job in our professional schools of medicine, nursing, pharmacy, social work, to prepare people in that primary palliative care role in the aspects of spirituality?

Christina Puchalski:

Don't think we're as good at those levels... nursing I think we are. And largely that's thanks to Dr. Betty Ferrell and her colleagues. I'm limited in what I know what nursing school does, but I can see the ELNEC program and others. I think we could do much better in medical school and in other professional schools. I think that's a huge area. I do think that we're beginning to do better at training the generalists or at least having, for example, primary care doctors I know who are very well in palliative care and are trying to practice these principles. So yeah, I think there's certainly a need in education, but I think we're doing better in all those areas. I mean, don't you think there is?

Lynn McPherson:

I do think we're doing better. I was surprised about a year ago, we took our 17 year old poodle, miniature poodle, to the vet and she brought up have you ever heard of the term palliative care? And my husband was like, "Oh God, don't get her started." But yeah, it's even permeated the vet care now.

Christina Puchalski:

There is. I mean, so about four or five years ago, a new specialty within veterinary medicine on palliative care. But many years ago, now would be about 10 or 12 years ago that I took my cat to the vet, and they actually asked about her goals of care. And I sat there and I said, "I need to have a medical student here with me."

Lynn McPherson:

Exactly, exactly.

Connie Dahlin:

Well, and they also have done a better job. I mean, I've had to put down several animals and they're sending you a bereavement card, right, because they know for some people... so they've got that down. I think the other part that's really interesting is I always worry about the spiritual part sort of being put on the chaplain of the team, but yet they're part of the team. Right? And so, trying to make sure that they are not having to take care of the team too much because they need to be part of that team. But then the other part is like what is the... there's been such a variation and I just had this conversation because every chaplain I have worked with has been excellent and can have goals of care conversations probably better than the clinicians, because exactly what you're talking about they can get into that spiritual part and get into those values.

And it was really funny because somebody said, "Well, that's out of their scope of practice." And I'm like, "What? I mean, really? No, I don't think so because I also have had situations where I might be with the patient's family and having one conversation and the chaplain has been with the patient and does a wonderful job and is actually the key to this success." And so it's interesting, I think, about the labels we put on to people when we get into the spiritual realm, because I think the flip side also is I work at a community hospital. Our chaplain department isn't as strong as it could be, but some of the nurses are comfortable to a point but then it's like one question of like, what do I do with the spirituality piece, and then they'll be like, "Okay, now we need a chaplain."

Rather than sort of the next question being, "Tell me what you mean by that? What are you looking for?" And so, I don't know if it's the discomfort because, I will speak for the nurses, we like to fix things and we like to tie things up in boxes, and so it might be hard for people to kind of sit with that. But I almost feel like all of us need to go through CPE or something so that we all feel comfortable and can support our colleagues in a better way.

Christina Puchalski:

So, I have a couple of thoughts on that. First of all, yes, chaplains should be involved in goals of care conversations, but part of the goals of care conversation is also prognosis and being able to convey that. So, I think ideally it's done jointly or there's separate conversations. I think when we think about what would success look like in terms of spiritual care within palliative care? Well, and it's also true of care in general but let's stay with palliative care, that every team would have a chaplain, as well as a nurse, a doctor, a social worker, therapists, et cetera, whatever the context is in. Right? And that everybody on the team would address spiritual issues and not just a chaplain dump, which is I think what you were sort of alluding to, George Chanza once said we don't want chaplain dumping, we actually want you guys to do something. Right?

So, we are there, we're human beings. We're bright. We can have conversations with our patients. We should be able to assess for spiritual distress. So, it involves knowledge. I think we need much more training, hence our interprofessional spiritual care education curriculum, ISPEC program, to train clinicians on how to do this in their practice, but all clinicians should do that. And all clinicians should be involved in including a spiritual question within goals of care discussion, as well as cultural and other kinds of questions. But we have to recognize, and I think this is where we in spiritual care are trying to do what palliative care did, is palliative care was successful because of, I think, two major areas. One was training. Training the workforce. And the other was the demonstration projects and eventual pilot research projects and developing the research in the field.

So, it's true for spiritual care within palliative care and within care in general as well. We need training to know how to do this as clinicians. We also need to know when to refer to a chaplain and when not. We need to know how to refer to a chaplain. And a part of that is we need to advocate with our hospital systems to have chaplains. Not all, my hospital included, does not have what I think is an adequate chaplaincy program. So, we need to make sure that the chaplain on the palliative care team is not just 10% of the palliative care team, but is fully part of the palliative care team, and has time to be fully integrated so that when we say spiritual care is fully integrated it means that at every team meeting it's addressed. That in rounds, it's addressed.

That the hospital makes adequate provision for adequate chaplaincy, not just one per team, but whatever the size of the hospital is or the services and that and that all the clinicians are trained in how to do this at least at a level one course. So, our ISPEC course there is a train the trainer because we want to train people to go back and train others, but they don't go back with nothing. They have an online ISPEC course like ELNEC, it's modeled after the ELNEC program. So there is at least an online course that clinicians can take. And our goal is to bring chaplains and clinicians together to these training courses, to do what I just said, that the two go back, the clinician and chaplain go back to be leaders in their setting. And that sends a very strong message about the importance of both sides of the team, the generalist, spiritual care professionals, us and the expert, which is the specialist, which is the chaplain. So I think within spiritual care, we have a long way to go.

I think palliative care in general is way ahead of us, and we're following their example in terms of how to create a field and how to do what's necessary. I think palliative care is an incredible example of educating the workforce early on and developing these demonstration projects and the research to

make it successful. We are all at a place, Mary Lynn, as you just said, in terms of education, training the workforce and then training students, the medical school, nursing school, social work, et cetera. I do believe in both those areas we need to continue to do that in a very sustainable way and in a very thoughtful way. I think we have a ways to go with that.

Lynn McPherson:

Would you like to share any information about GWish and are we ever going back to Lord's again?

Christina Puchalski:

Lords, you mean Assisi?

Lynn McPherson:

Oh, Assisi, right, okay.

Christina Puchalski:

Yeah, so GWish we are very actively involved in some of the work that I just talked to you about, our ISPEC course, our next one is in October, it will be virtual still because of where we are with the COVID virus. And that's going to be October 14th and 15th online and we check our website out for applications. We'll be doing more mailings and we'd love if you would share that as well. And we do the Assisi retreat every year for healthcare professionals. I want to let you know it's not just for religious people. We get people from all over the world of many different backgrounds, atheists, agnostics, religious, not religious, cultural, different specialties as well. It's really, it's just an incredible journey. And we had one online again this year, but we are hopefully hoping for next week, we have a reservation in Assisi for next July.

So, we'll be sending that out as well. And then, in terms of something I think that you both mentioned, is how do we train our clinicians to be present, to be really present? So we have a program called GWish Templeton Reflection Rounds that we've piloted in about 18 medical schools, and a lot of people have integrated that into their settings. So, we would love to do more with palliative care teams around reflection rounds. I think that is one way we focus on compassionate presence as a competency and how we can learn to both be heard in that compassionate way, but also how to facilitate those groups so that we can work with medical students and nurses and nursing school and practitioners on how to teach through experience, what it means to listen to someone at that deep level.

Lynn McPherson:

A lot of qualitative research in what you do.

Christina Puchalski:

Yes, yes.

Connie Dahlin:

So I think you've mentioned, I mean, sort of how we can improve that. What do you kind of think in terms of, for our students who are the leaders, things that they should be thinking about for the future and both in moving palliative care and in their leadership?

Christina Puchalski:

I think what I would say to the future leaders is, and it depends, the leaders, what their expertise is, I think before we started recording that you told me that it's a pretty diverse student population that you're going to have in this doctoral program. We certainly always need input. And I'm always looking for policy leaders to teach us what it takes to create system change and culture change. It takes a long time, I think, to make it, even as we're thinking about generalist palliative care or around spiritual care, how do we have everybody within the system recognize that this is important and at some level change within themselves but create change in a system? And then, how do you make the policy leaders recognize that this is an important area? And again, within palliative care, there's been tremendous progress in that area. I think for those people that are inclined to do research, what does that look like?

What else is needed within palliative care in terms of research and in terms of making the case? Again, palliative care has done this since the nineties, the research work, so there's been incredible work. But what else is needed to tell the story from a research perspective? Communication. We're still struggling over the word palliative and there's always the is there a better way to speak about it? I love the word palliative. You know, to cloak someone, I think it just is a, to me, a wonderful description of what we do in palliative care. But as these future leaders are coming up, what do they think? What do they think are the major communication messages? What are some of the areas where we haven't reached?

What for example, in medical and nursing school we've made some progress, but not where any of us, I think, on this call think we should be. So in education, who are the educators in this group? And what will their contribution be to education in this area, both within palliative care and all its domains as well? And anything payment structures, again, that always is an ongoing conversation. Again, Diane Meier and her group at CAPC have done incredible work, but we're always struggling because I think the challenge to all of us, namely all the palliative care practitioners such as myself, but also spiritual care, is as we are moving to RVU's and other ways for financing, that becomes the predominant way to look at healthcare. And what happens when people are all of a sudden seeing patients in 10 minutes, right, or in five minutes? What are they going to attend to?

They're going to prioritize as to what's important in that visit. And what I see is so important spiritual care, for example, we want to make sure that spiritual distress is addressed and not seen as something that's not relevant. So, I look to the students in your program to think of ways to make sure that suffering and spiritual distress and existential distress is in the front of people's mind that palliative care is in the front. It's not optional. We need to think about creatively, how to have the principles that we've taught for say 50 minute or one hour visits. How can that happen in a 15 minute visit? That is the crucial issue in training generalist palliative care professionals. It is possible to do this in 15, 20 minutes. We just have to think strategically how to message that and how to say there is something that should never be unaddressed, and that is pain, emotional distress, spiritual distress, those are the things that should never be left unattended to regardless of how limited that visit may be.

Lynn McPherson:

I just need to create a new course in the program and have you teach it basically.

Christina Puchalski:

Oh, happy to do that.

Lynn McPherson:

Okay. Dr. Puchalski, thank you so much.

Christina Puchalski:

It's been great talking to you.

Lynn McPherson:

I'm a great admirer of your work. You do a wonderful job. I think I shared with you before that your talk on miracles was, I'll always remember that because it was so impactful. So, thank you so much and Connie, thank you too.

Connie Dahlin:

Thank you.

Christina Puchalski:

Good luck with this course, and if there's anything I can do, I'm always happy to help.

Lynn McPherson:

Thank you so much. [crosstalk 00:35:13].

Christina Puchalski:

Thank you.

Lynn McPherson:

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.