Dr. Lynn McPherson:

This is Dr. Lynn McPherson and welcome to Palliative Care Chat, the podcast series brought to 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 course work in the PhD in palliative care offered by the University of Maryland, Baltimore.

Connie Dahlin:

Hello, everyone. Welcome to one of our PhD in Palliative Care podcasts. My name is Connie Dahlin and I'm one of the faculty for the University of Maryland Graduate Palliative Care Program. I am joined as always today by Dr. Lynn McPherson, who is the Director of the Graduate Program of Palliative Master's Program at the University of Maryland.

Today, we are interviewing one of our colleagues, Chaplain Katrina Scott. Katrina has been a chaplain for 15 years. She was at the Mass General Hospital Oncology Department, but also was a palliative care chaplain liaison. We were excited because she was actually one of the first couple of certified chaplains in palliative care, which if you listen to one of our other podcasts, there aren't that many of them still after this many years, and so that's a big honor.

Katrina actually has an interesting career because her first career was as a cinematographer and editor and a bartender because we know people that are in cinema, they always have to do other things to support that. She had a lot of other things to be talking probably to a lot of people and hearing about people's thoughts of life, and so then she went to Divinity School in sort of her more seasoned aspect of her life and had her education at Mass General Hospital.

I actually got to work with Katrina on our palliative care team. I think the other thing that's really important is that Katrina was part of The National Academy of Medicine's Roundtable, which we will have as resources for you, where they did a series of focused conferences that would look at different research questions that came off of the 2014 Dying in America Report, which was, again, one of the seminal reports about what it looks like. We have those for readings and one of the interesting things about those is that some of the issues from 1997 hadn't really changed in 2014. It's still been an issue in this country. We're still working towards that.

Katrina has continued to work in that role, is also faculty for the University of Maryland, and so we feel like it's so important to think about the different disciplines. Again, kind of thinking about what is going on in chaplaincy. Welcome, Katrina.

Chaplain Katrina Scott:

Thanks. I'm happy to be here.

Connie Dahlin:

I've given you a little bit of an introduction. I'm wondering if you want to talk a little bit more about... You obviously decided to go into chaplaincy, but then you also were really kind of drawn to palliative care. Do you want to talk a little bit about that?

Chaplain Katrina Scott:

Sure, thanks. My first day of Divinity School, I went to Harvard Divinity. It was September 10th, 2001-

Connie Dahlin:

Wow.

Chaplain Katrina Scott:

... so it was a big day the next day. I had started my goal of going to Divinity School as a humanist I must add because I'm not theistic. Was challenged from the get-go, but I really have a belief that everybody has a belief system and that part of empowering people is, especially in times of trauma or serious illness, is to help people to reconnect with what their beliefs may or not be and how they may or may not have changed through those difficult times. Chaplaincy was unknown at that time at Harvard. I started a brown bag luncheon with the Counseling Professor, Cheryl Giles, to like kind of promote it as a career because no one ever... Chaplaincy was seen as a dumping ground. If you couldn't make it as a pastor, you became a chaplain. That's how you got paid.

What was a driving force for really changing quite a bit of that was CMS picking up chaplaincy, spiritual care as a hospice benefit, and that drove the market very quickly into people then looking for that type of job at end-of-life care, but very few people were getting trained in it. A couple of units of what's called clinical pastoral education, but really no formal training in providing care for people who were struggling through a very difficult time. That became my passion.

I also as a young adult cared for my grandparents and witness my grandmother, who had dementia and her six-year struggle of living, unable to speak, basically in a vegetative state. That was something that also really shaped my passion for providing quality care for people at end-of-life.

Connie Dahlin:

Talk to us a little bit about... You were first drawn or maybe it was just at Mass General you started with oncology patients and then you really were kind of drawn to kind of working with the palliative care piece.

Chaplain Katrina Scott:

Yeah. My first year of clinical pastoral ed, which is 400 hours of supervised visits in a hospital setting, one of the settings, anyway, was at Mass General. I was in the Psychiatric Unit in vascular care. My second year, I fell in love with hospital chaplaincy, so I went right away in September into a second unit while still starting my second year at Harvard over at The Brigham, and I rounded with Janet Abrams. I was really interested in palliative care through meeting patients at Mass General who are struggling.

That's where I met Vicky Jackson. She was a Fellow and that was a real eye-opener for me as far as becoming a person of value on a small team. It was really nice to get referrals from other clinicians, not just chaplains or family members. I stayed at Mass General. I went back to Mass General as a per diem and I ran into Vicky there and who was like, "Hey, you should come hang out with us in palliative care." That's how it started, and I met Andy Billings. I was still in psych, and then the person who had been the oncology chaplain became director of the department and I was offered his job, and so I went full-time into oncology in January of 2006.

I was glad I had that psych background of dealing with people who really... they weren't on solid ground, let me just put it that way. I think that's what a diagnosis of cancer puts you in. You're going along and life's like this, and you get a cancer diagnosis and you fall off a cliff. Some people are able to reintegrate themselves so that they reintegrate their cancer experiences just a part of them as receiving a First Communion or graduating from high school, but then there are other people that carry that

burden throughout their lives and it becomes a real focal point that they still... That's a hump they can't get over.

My role I found in oncology was just really like listening to people, companioning, and my mantra that I learned from a professor at Harvard was, "Always ask the question you don't know the answer to." One of my favorite questions was simply... I'm meeting a person for the first time, it would be, "Why do you think you got this illness? Why do you think you got cancer?" It could be, "I live next to a taconite plant," or downstream, or it could be because, "I prayed to," and this was one of my patients, "I prayed to God to take away the illness of my grandchild who was in-utero but diagnosed with an abnormality. My baby came out fine and two weeks later I was diagnosed with leukemia, so it's my burden to carry."

It's just how people make sense of their illness and then if they can learn from their illness. It really is the best thing that could happen I think.

Connie Dahlin:

Those are pretty amazing examples and I think really important for our students who are listening to this. I think sometimes people feel like, "Oh, if people are steadfast in their religion, they can find this logic for it rather than the spiritual meeting," and that even with the technology that we have in healthcare that there is such a deep spiritual meaning to this.

I know you and shared a number of cases, but I can think of a number of times where we had a cancer patient who would say, "I got cancer because I'm atoning for leaving my wife and I'm a devout Catholic." We had some others that really believed that they got their cancer for some other reason, that they had done something wrong.

Chaplain Katrina Scott:

"I had an affair." "I had an affair" was a very common one.

Connie Dahlin:

Right, and so just this interesting... I think what you speak of this humanistic part, whether it's religious or not, what the meaning is, which I think you bring up this really important part and you hinted at it of for many years there was this focus on the physical body, and then we kind of moved to the body and the mind. Then, kind of opening up to the mind, body, and spirit. Do you want to kind of talk a little bit about kind of why it's so important to bring all of that together?

Chaplain Katrina Scott:

Sure. One of my pet peeves is when a clinician says, "Oh, that person, they don't believe in anything." Whoa, what do you mean? Everybody believes in something? It might be a personable God, it might be a political system. I've met plenty of Marxists that's how they live their lives and that's what they get their meaning from, but a person's spirit is a way that you can balance your internal, what's happening inside, to externally what's happening to you.

If I have a belief in an organized religion that has a belief that suffering is good and that suffering can help me to get a direct access to my understanding of the afterlife, then my goal is not to dis your theology or your belief system, but to help you to hopefully be supported by it in a way that's healing, that isn't damning. Does that make sense? There's a lot of theology out there that people can grab bits and pieces. Can I share a story? Would that be okay?

Connie Dahlin:

Sure.

Chaplain Katrina Scott:

I worked quite closely... Mass General had a lot of Roman Catholic patients and I was born Roman Catholic and went to a Catholic girls boarding school, so I'd introduced myself as, "I don't have a collar, but I did go to boarding school that had the nuns." People would grab onto a particular part of their religion when basically what it was to keep another person alive, a loved one alive that in all cases on a vent, their feet becoming gangrene. Really, to allow a natural death, but people didn't want that because they were holding onto one tenet of their organized religion that said, "God gave people these machines to help people, so I'm not going to take them off the machine. It would be against God's Will."

Well, that's really not how it works, but people... I remember asking our full-time priest to go in to talk to the family and he came out and he said, "Katrina, they just can't let their Dad go. They're using, they're grabbing, they're holding onto this theology piece as a [inaudible 00:13:25] a wall against admitting that their Dad was dying." That was really interesting to me. I learned a lot from him, that that's what you do. You grab at straws when you're desperate, and also like the miracle question. People don't ask for a miracle if they've got a broken toe. They ask for a miracle if their loved one is nearing death, and so I welcome that.

That's always been my goal in teaching is to get clinicians to welcome the miracle question because, number one, it means that the family knows how difficult the situation is, and number two, you can join them in hoping, possibly even praying for that miracle with them, but also acknowledging, "If that's not to be, what else would you pray for? What else would you hope for?" That gives the person a way of hopefully reframing that "Oh, okay. Well, if God isn't going to allow this, what else would be important to me and my family?"

Connie Dahlin:

Well, and I think one of the things that sometimes I have done is when people say, "I want the miracle," I've also reminded them that we may have already gotten some miracles," that sometimes we didn't expect people to live that long, that we are having more time right now. Yes, we might have some more miracles, but also some reframing sometimes because you and I both know-

Chaplain Katrina Scott:

Sure.

Connie Dahlin:

... there are times when people have surprised us.

Chaplain Katrina Scott:

Yeah.

Connie Dahlin:

I just think of this presence, and so for our students, why it's so important to have an interprofessional team because you get into some situations that you're going to have to figure out whether clinically, administratively, or not, and sometimes it might be around different pieces of care, but I mean, I can

remember Katrina and I took care of a young man, Theo, who the family has let us use his name, who was a man with cerebral palsy. Had actually done very well. Had been in a work study program. There was a whole bunch of education about this, and he ended up getting colon cancer.

I think the thing that was very interesting for us is that he was in his 40s and his family had spent their whole life making life possible for him. They'd outfitted a canoe, they'd outfitted a bike, they'd outfitted this. He'd lived in a group home. Here was this person that they put so much into who now had this really significant diagnosis. We did the normal treatment and he got worse and then he ended up having a bowel perforation and had to have some other procedures.

I think the moment to me that was one of the most important in my career was that I ended up taking the family, the mother and the sister, to talk to them about what was going on and acknowledging how hard this must be. You have spent your whole life for this person, and Katrina was able to spend time with the patient alone and it was one of those beautiful moments where not that I moved the Mom and the sister to kind of let go, but of like just understanding that this was a change in role, so I had done that little bit, but Katrina actually got the patient to kind of understand how sick he was and to understand that he was going to make the decision to make it easier for his family. I don't think everybody was sure that was going to happen.

It was just one of those moments where we were like, "Oh my goodness." That could not have happened with a clinical conversation. It really had to happen that you tapped into a spiritual realm in such a poignant way.

Chaplain Katrina Scott:

Yeah. I also think it's introducing yourself as the spiritual care member of the team who is not there to do medical work. You're still there to do clinical work, but clinical work with the person's spirit. For me, it was he understood my role and I asked him how I could help him and what was most important to him at this time. He just with his... Is it called a lightboard? Typed out, "I don't know where God is. Where's God?" Well, you know, that's the question for the ages, right?

Connie Dahlin:

Right. Well, and I think, though, that's the part of sitting with that. You said you came from a humanist part, but I would just say in a normal part anybody who feels like they have an answer to that, that would make me suspicious, but that's just me. I think the other part is having the capacity to kind of answer that because I can remember I had worked with many chaplains when I started an urban hospice in Boston. We used to do rounds a lot together, which was lovely.

I had another chaplain when I was out on the West Coast when I was in Oregon and, again, just very well... It's interesting both of them were women. Very well-educated women who could give this holistic part, and then when I came back and started the palliative care [inaudible 00:18:52] at Mass General, the first times that we were asking for chaplaincy, we had a priest who was a very good priest but very uncomfortable with people.

I remember the first time bringing him [crosstalk 00:19:04] into a patient and he was sort of so nervous and he ended up dropping the Bible. I was just like, "Okay, this isn't really helping the patient," because they wanted to see somebody strong. I was thinking, "Well, what would I do [inaudible 00:19:17]? Well, I'm not trained in this."

The most important question for me that caused me the most consternation was I had a patient who was from Tennessee and we're having a really difficult discussion because she had significant disease and she just looked up at me and asked me if I was a Christian. You know, to this day, I can tell

you that I saw my life flashing through me because I'm like, "Well, am I a Christian? I don't now, I was mean to my kids the other day." I'm going through this whole confession, if you will, to like answer, "Am I Christian? Am I not?" For me, it seemed like minutes, but probably wasn't that long and she must have been watching my face, which was doing that movie.

She said, "I just want to know if you're comfortable to pray because I need to pray with you right now," and I felt like such an idiot because I'm thinking, "Really?" I hadn't been asked that question enough in a patient situation and that where that line is that we are taught I don't think in chaplaincy of that personal/professional line. Where does that line go? I just sort of would be curious if you kind of have some thoughts about how it is that chaplaincy because you can bring that? Then, the second part of the question is, how do we support you in that when we may not be as comfortable like I showed of a simple question and like going into panic?

Chaplain Katrina Scott:

I think one of the interesting things for me working at Mass General and rounding with the IDT team was having the Fellows and doing joint visits with the Fellows to model what a joint vision or to just talk about spiritual care might be. I remember... Oh gosh, he went to The Brigham after that. I can't remember his name, but he came out of a meeting with me and he said, "Katrina, you've got the power." "Man, I don't think so," but because they're just too busy kind of doing the logical kind of progression of things. Whereas, I think the interesting thing about spiritual care providers is that we're used to nuances and following the thread.

In prayer, it's one thing... Some people will pray in rote. They'll pray things that they know by heart, and I would always end with something if I knew it like a [inaudible 00:21:59] or Our Father, Hail Mary, or something to say something with the person so they can join me. Most of the time in prayer, it's really lifting up what the patient has said what they're hoping for in a way that they understand that you're lifting up those deepest feelings. It is interesting. People that have only been churched by a conservative group that follows a particular prayer or ritual is always kind of surprised, and doctors as well.

I remember once being with one of the bone marrow transplant docs with a patient and the patient asked if I would pray, and I looked up at him and I said, "Are you comfortable with this?" He said, "Yeah, sure," and I offered a prayer. Then, when I came up and he said, "If I knew what that was going to be like, I'd say yes to everything like that." He'd always like kind of walk out in the room, but I kind of put him on the spot by asking him if it was okay, knowing that he would be okay.

I think there's listening to the patient, hearing their fears, and letting the patient know that you've heard their fears is probably the most important thing that you can do for a therapeutic relationship between a person-to-person heart-to-heart, soul to soul, and it really... I will say this again, you don't ever want to tell a person that believes they're crazy. I had a nurse on one, a patient who was a colon cancer patient from Haiti and her beliefs were basic Santerian, that somebody had caused the evil spirit to get into her system to cause this cancer. The way I was approached to visit the patient was by a nurse who said, "Oh, Katrina, she's crazy."

I went in and I found out that this woman, how she got through the day was by reading Isaiah. She knew the Chapter of Isaiah in the Old Testament chapter and verse and she needed some quiet time, so we came up with a schedule. I went out to tell her nurse that maybe we need to... I'll get her some audio CDs for when she can't read that she can hear these words. I looked at the nurse and I said, "You know, can I ask? What's your belief system? Do you follow religion?" She said, "Oh yeah, I'm Catholic." I said, "Well, you know, you believe," what's the thing where they take the devil away from you? I know you know this, Lynn.

Dr. Lynn McPherson:

Exorcism? Exorcism?

Chaplain Katrina Scott:

Exorcism, right. Yeah. I said, "So, you know, this is basically what she believes, that she has evil in her that is not of her own volition." That was an eye-opener for that nurse, and so I did a lot of training also as well. I'll just throw this in. I oriented new nurses, every new oncology nurse. They usually would come in groups of four or five and I would be part of their daily orientation. We also did monthly orientations in a large group with all of the new hires at Mass General. They got an hour of what spiritual care was about.

Dr. Lynn McPherson:

Can I ask a question?

Connie Dahlin:

Sure[crosstalk 00:25:11] go ahead. Yep

Dr. Lynn McPherson:

How many palliative care teams don't have the resources to have a full-time chaplain? I hear over and over, "Well, you know, all chaplains are palliative. You can just call them the hospital chaplain." What do you think about that?

Chaplain Katrina Scott:

I'm with Lynn. I think that if CMS would cover spiritual care as reimbursable as they do in hospice for palliative care, the problem would be solved. In limited resources in hospitals, it's really up to the organization to pick up our tag, and some hospitals, especially a lot of faith-based hospitals see the value in that. In Florida, Seventh-day Adventist groups fully endorse and promote spiritual care as part of their wellness package, and the same at Mount Sinai in New York. They have a very robust program. They call it Spirituality and Health Wellness. I mean, they really tie the two together,

In palliative care, it's a lot different than... You have to be comfortable with dying. You have to be comfortable with your own view of death, and I really do believe that a lot of chaplains who are great chaplains, generalist chaplains who don't have a specialty in palliative care, aren't really comfortable with dealing with that. Connie, I know the priest you were talking about who did that and I knew him. I came to him once and I said, "You know, hey, this patient is really hopeless," and he said, "Oh, I'll go up and I'll give him some hope." I was like-

Connie Dahlin:

No.

Chaplain Katrina Scott:

... "No," that wasn't what I was asking for. I was just saying, "Hey, this person's a Catholic, but is very upset that he's so sick that they won't do this surgery, so he just wants to go home and drink a bottle of rum and die, blast into a coma."

He wanted to fix it, and you know what? This is one of my favorite quotes in the world. It's from Parker Palmer, who's a Quaker educator as well as Quaker theologian. "The human soul doesn't need to be fixed. It just wants to be heard." It's as basic as that, so are you comfortable in hearing somebody's deepest fears and not trying to fix them but to align yourself with them as a wounded healer and to be there with that person? You have to be trained in dealing with a lot of countertransference that comes up, especially in dealing with people that remind you of your family members who have died or who have suffered trauma.

It takes a lot of work, so I think having a palliative care certified chaplain, it's a lot of hoops to go through, but it's definitely valuable. We also... I would say a quarter of my time at Mass General was also spent in supporting staff. That's a big part of our job and I think the more trained you are the more comfortable you are in supporting people that have a lot of [inaudible 00:28:31] distress, especially people where their hospital grants patients a lot of autonomy. They'll go through with... Even though the community hospital has said, "No mas, we can't do anything else," these patients are on their eighth clinical trial and dying within a week of chemotherapy in their veins. It's aligning people, but also keeping a sense of self, and that takes some practice.

Connie Dahlin:

Katrina, you brought up a really important point. Taking care of patients is important and I think you were talking about taking care of the team. I think one of the things that I always worry about is at the same point we want to take care of our social workers and chaplains and not have them have to be the total caregivers of the team because they need support being a member of the team. What are your thoughts sort of a little bit on that balance? I know you did support people with difficult cases and supported the team, so how do you kind of be part of the team and then also be supporting that team?

Chaplain Katrina Scott:

Very similar to a valiant group. Chaplains should receive supervision. That's number one. If not monthly, well, it has to be monthly, it would be ideally, excuse me, every two weeks, especially with the director of your department and trusted colleagues. Also, education, 50 hours of palliative care education a year is mandatory to keep up your credentials. For regular board certified chaplains it's still 50 hours, but it's not specific to palliative care.

I don't know. I think it really is knowing where your own supports are. I do a lot of meditation, my own meditational practice plus walking my dog, having a relationship with my spouse, my husband Fred. That really supports me, but it's also getting your head around the fact that everybody dies. I'm there to serve people during that process of dying in a way that hopefully will be [inaudible 00:30:55] important with what that person wants. Whether it's chemotherapy like my brother-in-law within a week of dying, or choosing to not have any more treatment and to live your end-of-life, I don't know, scuba diving or something, something crazy. It just... It's supporting people and also knowing that self-compassion is part of the package and self-compassion breeds compassion.

I like John Halifax, who's a Buddhist priest. He has a great analogy. It's not clinician burnout, it's empathy hyperarousal. You know, when you emphasize so much with someone that you become their suffering and that is another thing that palliative care clinicians need to identify is that you can be with suffering and not become that suffering. It takes a different modality for each person on the team, but we [crosstalk 00:31:59] help each other.

Connie Dahlin:

Right, but I think you bring up a couple of things, and I think it's remembering in palliative care, we get involved, but we're not the only team that gets involved with this. We don't have the ownership. We just sometimes are more willing to explore a little deeper. I think the other part is exactly what you just said. We're not the family, we're not that part, and so we can care, but when the patient has to start taking care of us, that's a problem-

Chaplain Katrina Scott:

Oh, brother.

Connie Dahlin:

... and we've seen that a couple of times. I wonder, how are we going to get more interest? I hear you say the payment piece, but how do we get more interest in getting more palliative certified chaplains? Or even if they don't get certified, that they are sort of designating their practice of palliative care? What do we need to do with that within chaplaincy? That just feels that there's a shortage, obviously, and that we're going to need them as we go into this crisis of an aging population.

Chaplain Katrina Scott:

There's... You know, I Googled yesterday "palliative care chaplains," and there were so many entries and questions. "How do I become a palliative care chaplain? What is a palliative care chaplain?" I think the more people experience an older family member dying in hospice and needing a chaplain, hopefully they had a good experience with that chaplain who will then help them to understand that spiritual care is part of the package. It's Dame Cicely Saunders' model of total pain, and spiritual pain, I mean, there's a big study of over a thousand physicians addressing spiritual suffering as being adds to physical somatic pain. What was the outcome of the study? Yeah, physicians acknowledge it, but nobody had an idea of how to help. I'm like crying out, "Get someone who's used to dealing with spiritual suffering on your team."

I think the different professional associations, I'm involved in the board certification for palliative care, and we do outreach programs. We have special interest groups. We have a lot of reach out to chaplains, but I don't know why. I think people are still afraid. I think they like to have the backing of their congregation of their church, and I think a lot of people aren't willing to put in the water. They're afraid of drowning.

I have to be honest with you, and so I think the normalization of the dying process, the conversation project, for example, or the card games that are out, or even the movement for Death With Dignity Act are things that are on people's minds, especially in the aging Bay Boomer population, which I hate to say, but we're all probably part of that in this recording.

I think NPC and The National Catholic Association, who are the two bodies that actually have Palliative Care Specialty Certification are really pushing that. The other groups, there's the Healthcare Chaplaincy, which also does board certification and palliative care, and that's not a review. You don't have to write anything. It's just a question and answer, almost like an exam to gauge your knowledge of palliative care, but it's really integration on the team.

I have to go back to the bottom line is, you get what you pay for, and if you're not going to pay for it, you're not going to get it. There is movement. We did a big study with NARCS for CMS for the questions about spiritual care as part of the questionnaire is in palliative care and the push to get CMS to cover the cost of palliative as reimbursable and we try. It's in a couple bills in Congress now, so...

Connie Dahlin:

Well, you make me also think about one more thing that's really important is that as we think about palliative care, it's really important that we're using our chaplains as we think about faith-based palliative care and moving into so not just people coming to us, but us reaching out to the communities. That feels like it's a better link when it comes from the spiritual care provider. It may come from chaplain to their spiritual care provider into the congregation, then another way. Do you want to speak a little bit about that?

Chaplain Katrina Scott:

Yes, we do a huge outreach program, and I also want to add that The Conversation Project has their own Unitarian pastor, Rosemary Hudson, who does... I mean, Rosemary... I can't remember her last name, who actually does that That's her whole role in The Conversation Project is to reach out to other congregation and clergy members to give them the tools to talk to the congregation. There was also a large study done by Michael Balboni and the group at The Farber along with his wife Tracy, who's a palliative care researcher as well as radiologist. That clergy... When clergy are involved in patient care, those patients offer three times more life support at end-of-life than hospice.

Why? Clergy don't have the tools to feel comfortable in doing an advanced care planning discussion. They'd rather default that to it's part of God's plan and life at any cost, especially with the decline of people going into Ordination Track as more and more people become unaffiliated. I talk about the rise of the nuns, people that are not looking to join a congregation or an organized religion. 20% of all Americans, it's greater for those under the age of 30, but 20% of all adult Americans are no longer affiliated. The other group that's that high of the makeup is Evangelical Christians, so it's very interesting. We've got Evangelicals and the people who consider themselves spiritual, not religious.

That's part of my dilemma about palliative care chaplains. Who's going to care for that demographic when they're hospitalized if they don't have a clergy person who's been trained? It's going to end up being the team that's going to have to spiritually support that patient, and a lot of people just aren't prepared for that, but I think it's we're going to see it more and more, which is another push for palliative care education of spiritual care providers, for sure.

Connie Dahlin:

Wow, and yeah, I remember us having a conversation about this changing demographic and this unsure because, then, what do you do? I was kind of going to the sense of my vision of palliative care is that we started in the community and we really only go to the hospital if necessary, so if we're moving that back, then the community is part of it. Then, the spiritual-religious piece becomes important because the people don't designate, how do you support? It's just a very interesting process.

Chaplain Katrina Scott:

Yes, and it's all twisted up because clergy who have been trained and who have done CPE, most groups except for the Catholic Church mandate one year of clinical pastoral education for ordination across the board. Rabbis, Christian ministers, they all have to have that one unit, but it's a general unit. They don't have the dying conversation because half of the half of people that have palliative care teams want someone on their team who can actually understand what's going on and not that they have to teach-

Connie Dahlin:

Right.

Chaplain Katrina Scott:

... so it's kind of a double-blind. You want clergy involved, but you want clergy who are knowledgeable, so then the palliative care chaplain from the hospital has to go out and teach the congregation and the pastor and hopefully give them a few tools as how to discuss things, but yeah.

Connie Dahlin:

That's [crosstalk 00:40:56] yeah. Interesting [crosstalk 00:40:57]-

Chaplain Katrina Scott:

A good piece. That's why they need this program.

Connie Dahlin:

Well, I mean, I think that what we're draining say, so for the students who are watching this, this is an interesting part that we do need an interprofessional team. We need all of us, and that particularly when you have some of us that... I hear it still. It's like, "Oh, they have a spiritual issue? I'll call the chaplain." Well, that's if you have one, and if it's not, then you have to have some competency to be able to be in the room and figure out how to learn that. I think the other part of knowing that you might make some mistakes, but you're trying to figure out how to have that to be still and to be quiet and, like you said, asking a difficult question and knowing that there might not be answers, but some people just talking it through.

This has been really interesting, Katrina, because I think this whole clinical realm and kind of thinking some of the issues of chaplaincy and pastoral cares that we're going to need more people and there's going to have to be more of a strategy to pull people in. Otherwise, I think the other part I would say is people talk about doing palliative care, but if you don't have access to, and I don't necessarily mean hire, but I mean access to all of the disciplines, then you're doing probably more primary palliative care. We're going to have to kind of recognize that and teams will have to kind of understand that if they aren't dealing with the spiritual and the social and that they are not dealing with the total pain and missing some of that.

It's been really great. Lynn, do you have any last minute questions or thoughts that you want to jump in with?

Dr. Lynn McPherson:

No, I think it was a great overview. Thank you, Katrina.

Chaplain Katrina Scott:

Oh, you're welcome. I do just want to say my years at Mass General as well as a lot of my colleagues, they would round with an IDT. They would be there when you needed them, but they also served other units. I was in oncology, so I'd have relationships with patients for years and then see them at end-of-life, but having a dedicated palliative care chaplain for your team is as important as having a nurse practitioner or a doctor.

It truly is because you want someone to focus with your team, with that patient, and not getting phone calls and referrals from other clinicians off of other units. It's you're binding someone's hands, so think the binding of Isaac, but you're binding someone's hands and providing really great clinical spiritual care.

Connie Dahlin:

Right. Well, thank you so much. Thank you for all that you've done in terms of kind of pushing forward the role and teaching a lot of clinicians along the way and all of the work that you've done with your patients. We're really happy that you've felt that this would really be a good conversation with us, and we really appreciate all that you've offered with us.

Chaplain Katrina Scott:

Yep. Thank [inaudible 00:43:57]. Yeah, thank you.

Dr. 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 [inaudible 00:44:16] presentation is Copyright 2021 University of Maryland. For more information on our completely online Master of Science, PhD, and graduate certification program in palliative care, or for a permission request regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.