

Dr. Mary Lynn M...: Hello, this is Dr. Mary Lynn McPherson. Welcome to Palliative Care Chat, the podcast brought to you by the online Master of Science and Graduate Certificate Program at the University of Maryland. I am super-duper excited with our guest today. We have Ms. Layne Heller, who is a student in our Master of Science in Palliative Care program. As a matter of fact, she is graduating this week. How awesome is that? But what's really interesting is she is a Christian missionary who lives in Mozambique. So welcome, Layne. How are you today?

Layne Heller: I am doing well. Thanks for having me.

Dr. Mary Lynn M...: Absolutely. I've been following Layne's posts in her causes throughout the two years, and I kept saying your story is so interesting. We have got to record a podcast, so you're not getting out of here alive until we nailed this to the wall. So here we are in the last week [inaudible 00:00:56] program. So we're very, very excited.

Our listeners, I'm sure on the edge of their seat, trying to figure out how did a sweet young thing like you end up in Mozambique with your husband, Jon, also a missionary and your lovely family. So what is the scoop? How did this come to be?

Layne Heller: Yeah. Okay. It's hard to know where to start, but I'm going to start when I was about 20. I was really needing a change of pace in life. And so I decided to sign up for a two-month Christian mission trip to Botswana Africa. I'd been to a lot of countries before, but I hadn't been to Africa. So it was on that trip that I fell in love with Africa as a continent. And while I was there on that two months trip, I actually heard about an opportunity that I could return for nine months and I signed up while I was there. I was ready to go back.

So it was during that nine-month trip that I fell in love again, but this time with my husband, Jon, who was actually living there at the time working as the IT manager for the ministry that we were volunteering with. And I was in the middle of my English degree at the time. So after that nine months, I went back to the States to finish my degree before marrying him. And I had picked English because I loved missions and traveling, and I felt English would be an open door to international living and missions. And when I was deciding what degree path I wanted to go on, it was either English or Nursing and my family is a family of fainters. So from the time I was little, the mere sight of blood would make me dizzy and nauseous, and my mom coached me from very little how to put my head between my knees and get my head below my heart and breathe. So all that to say, I picked English.

So I graduated 2008 with my English degree and I married my husband the very next month. And when we got married, we decided we wanted to venture out and do something as a couple new. And we wanted to go somewhere where there was a need that was not being met. We were really comfortable in Southern Africa. And so we started doing some research and asking around and

trying to find out where we should go, and we set our hearts on Southern Angola. So instead of wedding presents, we asked for funding to help us go on a research around the world trip.

We had heard about a ministry in Uganda called Aidchild, started by a man named Nathaniel Dunigan. And his ministry when it started, he would adopt children who had been abandoned in the hospital with HIV AIDS, with six months or less prognosis. And really his heart was to take them out of the hospital and give them a family and a home to die in. Now, his ministry has changed a lot because he realized once you get these kids on ARVs and in a stable home, they actually live. So his ministry has changed a lot, but it was his original heart that inspired us.

So two months after getting married, we took off on this around the world trip. And we started looking into just different foster care, orphan care models in different countries. And we also wanted to stop in Angola and scout out where we might want to live and what kind of ministry we could do there. And we had traveled a lot around Southern Africa, but when we got to Angola, we realized you have to speak Portuguese. They don't speak any English. And we had heard that, but I think we had expected, maybe they would speak a little bit of English, and they didn't. So we realized after that, around the world trip that we needed to go to Portugal and actually learn Portuguese.

We went back to the States after this, around the world trip, and started looking into Portuguese schools in Portugal and visas to Angola. And visas to Angola turns out to be really hard to get, to actually live there full-time. And so we just trusted God would make a way, and we went on to Portugal to learn Portuguese. And while we were in Portugal, we met a Portuguese couple who were also missionaries, but they were missionaries in Mozambique. They were home visiting family.

And they said, "Hey, while you're working on your visas, why don't you come to Mozambique? And you can volunteer with us being an African context, not lose your Portuguese." And so we said, that sounds like a great idea. So we headed to Mozambique and we didn't know at the time, but I'm the wife of the couple that invited us actually had a little preschool program at the government hospital where she would work with oncology kids because when they're there for chemotherapy, they would actually have to miss a lot of school. So this lady, Elise, and a group of women had a little preschool program for these kids to kind of fill in that gap.

And when we went on our very first visit, we were taken on a tour of the whole oncology ward. And we saw that the kids were getting all this attention and all these donations and the adults were on their own. And we realized, "Hey, this a need that's not being met." And so we had a whole lot of time on our hands. We were just kind of waiting for our visas. So we started visiting the oncology ward

five days a week and we were practicing our Portuguese, and we got to provide a little bit of distraction to some patients who stuck in their beds.

We began to notice that some patients came and went and some we're stuck and never left. So we're like, "Why is this happening?" And we realized at the time, Maputo, the capital city was the only city in the whole country where patients could get chemotherapy. And so patients who lived really far away actually had to stay for the duration of their treatment because they couldn't come and go. And they would essentially live at the hospital for six months to a year. And we began to realize, "Okay, we want to focus on these patients because they don't get afternoon visitors. They have no family." And so we began to specifically visit these patients. And so over the next two months, these patients really became our friends because we would spend a couple of hours every single day with them.

We learned their stories. They learned our stories. We really fell in love with them. And then one man that Jon had been close with he died. He was a teacher, a dad. We had learned all about his story and this was really hard for Jon. It was no longer just a patient. It was a friend. Then it was a few weeks later when I got to the hospital; I noticed a lady that I had met before it was there again. And she called me over, and when I got to her, I could tell she was in a lot of pain. And the hospital was actually out of Morphine and there's nothing they could really do for her. So I didn't really know what I could do, but I couldn't do nothing. I needed to do something. So I just stayed with her. And I stayed for hours. I did not feel like I could leave while she was grieving in pain. And so she would lean on me and I would pray with her.

Finally, that night she fell asleep and I called my husband to come pick me up. And I left. It was late at night. And the next day when I got back to the hospital, she was still there, still in a lot of pain and even worse, and so I stayed again and we just bounced around from the floor to the bed, to the bathroom. We were just going all over, trying to find a comfortable position. Again, the hospital still had no Morphine. So this happened for three days until the third day, I climbed into bed with her and her head was on my shoulder and her breathing began to slow and she actually died in my arms.

Dr. Mary Lynn M...: Oh my goodness.

Layne Heller: I had never even seen a dead person at this point, much less held one. And so I just laid her on the bed and I ran from the ward sobbing, exhausted, but I was relieved in that moment too because her suffering was finally over. And it was almost in that very moment, I think I was waiting outside because my husband had left me there at the hospital with her. I was waiting for him to get there. And if it's almost in that very moment that I knew this was what I was meant to do. I felt like this will not be the last time that I do this. And so it was like maybe three days later, our visas to Angola came through, which we had been waiting months and months and months for it, and they came through. So we packed

our whole lives up in our land cruiser. And we drove across Southern Africa and went to Angola and it was on that drive that we started dreaming again and reevaluating what we wanted to do. So then we started thinking, "Okay, maybe we don't want to focus on just children. Maybe we want to do adults too. And maybe we'll just do sick ones, not just HIV."

So we just started reevaluating this and we really started to dream, "Well, hey, maybe we can give patients a place where they don't have to ... One of the things that I noticed when this patient when we were bouncing around and she was in pain, all the patients around us were just staring at us. And so when she died, we were in a room with 12 beds and there were 11 other patients there. And this lady was in so much suffering and nobody knew what to do. Everybody just stared and it felt like such an awful way to die. And so we started thinking, "Well, what if we could have a comfortable home where somebody could have dignity and privacy?"

We went to Angola and we were looking around and we realized the need in Angola wasn't really the same as it was in Mozambique. And so we decided to go back to Mozambique. And we had identified at this point two things that we felt we could do something about. We felt we could do something about the patients that were from the North and getting chemo and kind of stuck up at the hospital. And we felt like we could do something about patients who are dying alone without people around them.

Dr. Mary Lynn M...: Mm-hmm (affirmative). I was going to say, are the patients who come to your house; are most of them because they're just getting chemo or do some come there to die?

Layne Heller: All of the patients that come to our house are from the oncology. So they always start off having chemo and radiation. And if they decide to stop, there's the option to stay at our house. Yeah. So we are only partnered with the oncology ward here in Mozambique. And so all of our referrals come from oncology.

Dr. Mary Lynn M...: So tell us about your house. How did this come to be?

Layne Heller: Yeah. Most houses here actually come with maid's quarters. And so they have a room detached from the house, but right behind it with one or two bedrooms. And so we were renting a house and we were like, "Hey, we could just turn those rooms into patient rooms and we can remodel that. And so we wrote up a proposal to the hospital about our idea for this. We also were realizing, "Okay, these patients, if they had family close by, they would be discharged." So my husband and I were feeling like we didn't necessarily need special medical knowledge. We would just be the standard family for them. So these patients would have gone home if they could have, even some of these patients who are dying at the hospital alone would be discharged to die at home. They just

couldn't get home to their families. So we originally were just like, we will be a standard family for those who don't have one.

And so we actually remodeled those rooms. We turned a garage into a kitchen. We bought beds and dishes and towels and we remodeled it. And then we waited and waited and waited, and it actually took three years for our project to get approved. And it actually got approved when I was seven months pregnant with my third baby. And I was feeling like it was the worst time ever, but it turned out fine. So we got approved, but then we got to the hospital and started inviting people to our house. And people were actually a bit scared to come to our house because they were thinking, should we leave the hospital move in with Americans? It was just this strange idea.

We have a little resistance when we started inviting people to come to our house. But there was one brave man who had had cancer before and known Jon and I and had come back with a reoccurrence, and he said, "I'll go, I hate the hospital." So he came, he was our first patient. And then he started reporting back to the patients in oncology that, "Hey, it's really great here. You should come." And we filled up really fast. So we had four patients, we had two men and two women. But it was that first round of patients, one night, one of our patients started not breathing very well. And we rushed to a private clinic nearby. They ended up taking two liters of fluid out of her lungs. She had really bad pneumonia. When that happened we realized, "Hey, living with cancer patients, maybe we actually do need some medical knowledge."

Then another round of patients came, and one came with a really massive wound on his head that needed daily changing. And so the nurses at the hospital coached us a little bit and we did a lot of research and it turns out we were pretty good at it. When you do something out of compassion, when it's not just a job, it makes a difference. And so we were actually pretty good at this. And then more patients started coming through in feeding tubes, colostomy bags, all of these things. And we would just frantically research per patient. And the hospital was really good about coaching us do what we needed to do. So we kind of learned on the spot. I mean, you know as well as I do, that even caregivers in the States can learn a lot and you can coach them and teach them. And so that's pretty much what we did.

Now, I do want to remind you that if you remember, I was fainting at the sight of blood. So really God miraculously changed me. It's a joke that I tell people when we get to the States, nobody better cut their butt or their arm or anything like that because my grace is only for Mozambique. So I'm scared in the future, but at least in Mozambique, God really took all of that away, which was amazing.

Dr. Mary Lynn M...: Absolutely.

Layne Heller: But after this, we like consistently had to wait in line for our house. We could take four patients. And every time my husband got to the hospital, there were people saying, "We want to come. We want to come." And we kept having to say no. The original vision of our house was that we wanted to be a family for patients who didn't have one. So we never wanted to grow so big that we felt like we took them from one institution to another.

Dr. Mary Lynn M...: Sure.

Layne Heller: But at this point, we also realized we need to grow some. And so we started thinking about what we would be comfortable with. And the next time we were actually in the unit States, we kind of cast the vision out there. "Hey, we'd like to buy land, build a house, build a center." And nobody really bet, nobody got on board with it. And so we just decided, we'll just keep being faithful with what we have. We'll keep doing the four patients that we can. And then it was like a year later, we're in Mozambique and we get a random phone call in one September day from a generous American family, they had just sold their business and told us, we feel like God has told us to give you \$300,000-

Dr. Mary Lynn M...: Holy moly.

Layne Heller: ... to buy a piece of land and to build the center. So absolutely miraculous. Obviously, I cried my eyes out. I could not believe that it was happening. It was a miracle. So now we have built a center and we moved into our new place about three and a half years ago. And we have room for 12 patients. And then we have one bed for hospice. That's actually inside of our family home, but we have 12 beds, kind of like I was explaining earlier, just a bit detached from our house. There's a sidewalk in between our house and [crosstalk 00:19:47].

Dr. Mary Lynn M...: [inaudible 00:19:47] have covered all that?

Layne Heller: Yes.

Dr. Mary Lynn M...: Wow! The dollar is further in Africa. Huh!

Layne Heller: It does. I mean, it's a beautiful home. We learned a lot of things about building. It was a trying six months to a year of building, but we managed. And so now our project is called Casa Ahavá, which means the house of love. Ahava is a Hebrew word for love, that actually means ... it's not a romantic love. It's the kind of love like somebody screaming at your face, throwing things at you. And you're still say, "I choose to say, I see the very worst side of you and I'm going to stay with you." So that's why we named it Casa Ahavá. And we have now housed about 65 patients. And only two patients have died on purpose at our house.

We realized early on that most patients prefer to die at home. Here in Africa, it's really important to be buried in your Homeland. There's a lot of traditions in

that first year after burial. And so it's important for the family, for the bodies to be buried close by so that they can take part in all those rituals. And It's really [crosstalk 00:21:23]-

Dr. Mary Lynn M...: What do you mean died on purpose?

Layne Heller: They knew they were dying and chose not to go home. And their family knew that they would stay here and knew that they would die in here.

Dr. Mary Lynn M...: It wasn't assisted suicide sort of thing?

Layne Heller: No, no, no.

Dr. Mary Lynn M...: Okay. [inaudible 00:21:43], of course.

Layne Heller: Yeah. So we've just realized that a big part of our ministry is actually advocating for patients to stop chemotherapy when they still can travel home. And when they still can have a few good months at home, if that's where they want to die, because we kept seeing that the doctors would just treat them until they were too weak that they didn't have that choice anymore. And so now we're just able to sit down with the doctors in private and ask, "Okay, well, what do you think the real prognosis of this is? And do you think it would be better?" And sometimes the doctors just don't want to have that conversation. It's a hard conversation to have.

And so actually, my husband's studying Thanatology, and recently he's begun; the doctors will actually call him to have that conversation with patients when the time comes, and he'll even sit with family members and doctors just don't ... they're way overloaded here. It's not necessarily their fault. They just have so many patients. So my husband has time that he can actually sit and spend 30 minutes or an hour with the patients and answer their questions and things like that. So that's a service also that my husband's able to offer.

Dr. Mary Lynn M...: So the IT specialist and the English major have made quite an impact in their little corner of the world. It's not just you and Jon, you have daughters. Yes? Tell me about that?

Layne Heller: I have four amazing daughters. I have a nine-year-old, an eight-year-old, a seven-year-old, and a five-year-old.

Dr. Mary Lynn M...: Wow!

Layne Heller: They love their life in Africa. We have a very big yard. They have cats and dogs, and birds, and fish, and they ran around on the roof of the house and they never wear shoes, and they think life is great.

- Dr. Mary Lynn M...: And do they interact with the patients? I assume they do since you've got this family type atmosphere?
- Layne Heller: They do, they call them "Tias" and "Tios" which is aunties and uncles. And yeah, they're spoiled rotten by our patients, quite honestly. My girls were raised ... like I said, I was pregnant with my third when we started our project. And so my oldest was only two at the time. So they really don't have memories of not having patients around, and they have become really accustomed to wounds and big bandages and they think it's quite normal. They also have learned a lot about death and we talk a lot about it, and they seem to cope pretty well. We've also when we go to the States, we see a counselor and we just make sure everybody's coping well. But up until this point, it seems like-
- Dr. Mary Lynn M...: That's great.
- Layne Heller: ... they're doing okay.
- Dr. Mary Lynn M...: And you homeschool them. Yes?
- Layne Heller: I do homeschool them. For the most part, I love it. But every now and then ... I think it was two weeks ago, I was looking at school fee prices nearby because I was about to throw my hat in, but I bribed them with ice cream this week. I said, if we can have five days without crying, we will have ice cream. So tonight, they got ice cream. It was a good week.
- Dr. Mary Lynn M...: Well, that's a win right there. How often do you come back to the United States or does your family come to visit you in Africa?
- Layne Heller: We try and get back to the States about every two and a half years. It's a very expensive endeavor and exhausting. And so when we go back, we try and spend a little shy of three months there. My husband's from Arizona and I'm from Texas. So we try and spend about half of our time in both places and just make sure we get to visit family, of course, but also it's a bit of work because our project runs on donations. And so when we're in the States, we have to just meet with everybody who supports us and give them updates and allow them to feel connected to the project there.
- Dr. Mary Lynn M...: So that's how your work is funded, through donations through your missionary?
- Layne Heller: It is. So we have a couple of churches, but a big part of our ministry is just families who give either monthly or yearly. Yeah.
- Dr. Mary Lynn M...: Great. That's wonderful. To go back to something you said very early, you said you fell in love with Botswana and then you were really drawn to Angola, but now you stayed in Mozambique. So what is it about Africa that you fell in love with it? It seems to me like a hard country. It's a hard life in Africa.

Layne Heller: It is, but it is magical. I don't know. There's just something about Africa. My parents have been here. I think most people who come here can't only come once. The people are wonderful. I feel like it's a bit of a slower pace here, which is nice. And yeah, I can't pinpoint it, but I know most people who come here can't stay away.

Dr. Mary Lynn M...: Well, I know that one of my favorite books series is the No. 1 Ladies' Detective Agency.

Layne Heller: Have you seen the videos?

Dr. Mary Lynn M...: I have not.

Layne Heller: There's a film and it's nice.

Dr. Mary Lynn M...: Yeah, I really enjoyed the book. So that's it, Botswana, I think, Isn't it?

Layne Heller: Yes, it is.

Dr. Mary Lynn M...: Yeah, it's so interesting. Tell me, what is the culture, if any of hospice and palliative care, what is the status of hospice and palliative care in Africa?

Layne Heller: Okay. Hospice and palliative care, Kenya, and South Africa and Rwanda are probably our leading countries. Kenya actually is the headquarters for hospice and palliative care on the continent. And Mozambique is really just new to the scene. Hospice is unheard of here where the first inpatient hospice facility, and like you heard, we haven't done it very much. And palliative care is kind of this new catchy word here. So I feel like, over the last couple of years, they keep flying in a few Portuguese doctors who will give maybe a week-long, two-week-long little seminar for the nurses and the doctors. So I'm excited. I feel like steps are being made. There is a Pain Unit that is trying to be utilized more and more.

Here in Maputo, we actually can get Morphine, sometimes Tramadol and Codeine. But once you venture out of Maputo, oftentimes the only pain medications you can get are Paracetamol and Ibuprofen. [crosstalk 00:29:08]. I was recently at one of those palliative care trainings. And there were doctors from all over the country who were just reporting the difficulties they have. And that was a huge one. They just cannot get their hands on pain meds.

Dr. Mary Lynn M...: I have a good friend, a physician who for years served as the medical director for the international hospice and palliative care organization of Sub-Saharan Africa. And I remember when she came back speaking about in the really remote areas where they had no effective analgesics, somebody with terrible pain went hide behind a big rock. And when they heard a truck coming, they would jump out to end their life on purpose. Is this true?

Layne Heller: Actually, Mozambique has a really high suicide rate. I'm not really sure all of the reasons why, but yeah, pain is rarely controlled well here, even with the Morphine that we have, I feel like doctors are just a little leery of it. So they're a little scared. And so to give patients more than 60 milligrams of Morphine is a scary thing for them. And I'm talking, if I could show you pictures of some of the wounds that we've had at our house, I just don't know how these patients manage. They are fiercely strong. But it's terrible suffering.

Dr. Mary Lynn M...: Oh my goodness. Do you have a big drug problem in Africa?

Layne Heller: We don't.

Dr. Mary Lynn M...: Yeah, because you don't have the drugs.

Layne Heller: Yeah. Now, I take that back. There's probably, I think there is a bit, but prescription drugs, no.

Dr. Mary Lynn M...: Do you have Cannabis?

Layne Heller: It is against the law. It actually became legal in South Africa recently. And we had approached the Pain Unit here to ask them if they could somehow approve it for our home. We were thinking we could maybe do vaporizers which we actually had to have a little bit of a laugh about because we said, "We'll be the Marijuana missionaries." But they said no way, not a chance.

Dr. Mary Lynn M...: Oh, I bet not. That's another thing you said is, are there sufficient numbers of oncologists in Mozambique? I guess not in the remote areas, but what are your thoughts on that?

Layne Heller: Yeah. So here in Maputo, we currently have four-ish. One of them is currently not working. So we have three oncologists working here and then we have three radiation oncologists. We just opened a radiation department. I think it's been about a year and a half now. So that was a huge step for us. But then we have two oncologists, it's in a town called Beta. It's towards the middle-ish of the country. So altogether we're talking five or six oncologists for the entire country.

Dr. Mary Lynn M...: That's not very many. So if someone lives in a very remote area, they probably don't get diagnosed until very late in the game. Correct?

Layne Heller: Exactly. The stories we hear from our patients, even who ended up getting here is that they go to the doctor with a small lump. The doctor gives them paracetamol, sends them home for two weeks. They come back, it's not gone. They'll send them home with antibiotics. And it's just this slow go. Usually, it takes up to a year before they get here, and by that time they've got a grapefruit-size tumor coming.

Dr. Mary Lynn M...: Oh, my. So is it fair to say there are people in Africa who die without ever having seen an oncologist or gotten chemo or anything?

Layne Heller: Absolutely.

Dr. Mary Lynn M...: That's very scary. Isn't it? Very scary. Goodness. Well, talk to me about something near and dear to my heart. So here I have this little English major, who's could use a button who faints at the sight of blood, taking care of 12 patients, maybe 13 patients. Has the master's degree had been of any help to you. How has it helped you?

Layne Heller: It has given me such confidence just to feel like I'm not looking up on my phone, all the resources and things that I need to do. Like I have a firm foundation of medications and pain management and even assessment that has been so helpful. We actually have a potential hospice patient coming who cannot speak or move right now. And I told my husband, "Oh, I need to get my nonverbal pain assessment out." And so there's so many resources. I mean, when you just look on the internet, you don't know what is sound and what's not sound. And so now I feel like I have this from just resources that I can just draw from for years and years. I can not be more thankful for the last two years it's been incredible.

Dr. Mary Lynn M...: Well, I think our listeners need to know that in our program people take the first four courses and then you take four electives and we've got a clinical track, which I always envisioned to be for doctors, nurses, advanced practice nurses, pharmacists, and physician assistants. We've got a psychosocial, we've got a leadership track and thanatology track. And Layne petitioned me to do the clinical track. And I was like, "Girl, you're an English major. What are you going to do in a clinical track with my MD, PhD, and Pharm.Ds, and DMPs, and all these people. And she's like, "I have a special circumstance. I have to do it." And I have to say, you did as well or better than most people in the clinical track despite not having that classical training. Again, this must be another intervention from God, along with the waving the fainting proclivity for you, because you really did rock it out. And I think God knew you would need these skills. So He empowers you to be able to do that.

So I think that's pretty darn amazing. It was a rare exception. I thought, "Boy, I hope I don't regret this." And I absolutely do not regret it. So, excellent, excellent job. And between you and your husband, you've thought of the cover, the waterfront between the physical and the psychosocial and the spiritual and the communication skills and the grief and bereavement and everything. So you're kind of a tight-knit team there.

And I guess in closing one last thing is how has COVID hit Africa? What's the scoop?

Layne Heller: The numbers are steadily rising, but we're talking somewhere between 20 and 50 cases a day. So very small. I would say it's just God's mercy. I know we're not

testing to the capacity that other countries are either, but my husband is doing a support group, sort of psychological support for the COVID workers at the central hospital. So he meets with them once a week and gives some encouragement, and then he'll meet individually with them. And so he's actually getting a good view of the ER and actually the beat there at the central hospital, which is the largest hospital in the country. And it's just not overwhelmed, pretty empty to date. Mozambique has a little over 1500 cases for the whole country. And we've only had 11 deaths. So we are so thankful for that. [crosstalk 00:37:09] But hope it's my dad actually has it right now in Texas. And it is hard to be far.

Dr. Mary Lynn M...: Well, I hope your dad pulls through and does well, and it's a mild case, but it is very, very scary. Goodness, gracious. Well, as you were talking, I was also thinking with this degree under your belt, I think you are in a great position to go educate people in the hospital about palliative care. You said the nurses [crosstalk 00:37:36] Portuguese visitors come. I think you could easily pull that off and do some staff development of your own, Layne.

Layne Heller: We are starting to brainstorm. I kept saying there's a lot of potential after this degree. I just felt like I needed to finish. So now that I'm done, we are reevaluating and kind of going to see how we can put this degree to best to use here.

Dr. Mary Lynn M...: So this is probably my ignorance, but does everybody speak English there or are there people who don't speak English?

Layne Heller: It's all Portuguese.

Dr. Mary Lynn M...: But you're fluent now in Portuguese. Yes?

Layne Heller: We are. Yeah. I mean every now and then, you can always find a few English speakers, but it is all Portuguese.

Dr. Mary Lynn M...: And are your children bilingual now too?

Layne Heller: I wish. They are doing okay. But because I homeschooled them and we use American curriculum, they just don't get quite the interaction that they needed to be fluent, but it is a goal and they know it's important. I tell them all the time you were born in Mozambique, you have to speak Portuguese.

Dr. Mary Lynn M...: Absolutely. Well, any last comments or thoughts, Layne as we wrap up? I really appreciate you doing this.

Layne Heller: Yeah. I just would encourage people that Jon and I are not exceptional people, and we didn't have exceptional training, but what we did is we just looked for a need and we evaluated the resources that we had that we could help with. And so just one person at a time, we started helping the people right in front of us.

And so sometimes I think the need is so large that we feel like we can't do anything, but that's just not true. If we look around our immediate sphere of influence and we just help one person at a time, a lot would get done.

Dr. Mary Lynn M...: Well, respectfully, I'm going to have to disagree with you because I think you and your whole family are doing magnificent work. I think you're doing God's work. And I think we could all take a lesson from you. So thank you so much, Layne. So again I'd like to thank, Layne Heller and her family for this time and everything that they do. This is Dr. Lynn McPherson, and this presentation is copyright 2020 University of Maryland. For more information on our completely online Master of Science and Graduate Certificate program in Palliative Care, or for permission request regarding this podcast, please visit graduate.umaryland.edu/palliative. And I would also like to encourage you to go to Layne's website, which is Jon and Layne. That's jonandlayne.com. It's an amazing website. Thank you so much.