Lynn McPherson: Hello, this is Dr. Lynn McPherson and welcome to Palliative Care Chat, the podcast brought to you by the online Master of Science and graduate certificate program at the University of Maryland. I'm very excited about our guest today. Dr. Arif Kamal, who is an associate professor of medicine at Duke University and an outpatient palliative care physician. Welcome Dr. Kamal. How are you today?

Arif Kamal: I'm very well, thanks Lynn for having me.

Lynn McPherson: Oh, absolutely. We're delighted you're here. You're a palliative care physician. Tell me, what is your normal pre-epidemic professional life look like? Tell us what you do.

Arif Kamal: Yeah. As you know the field of palliative care is growing very quickly and one of those areas of growth really over the last five years has been outpatient palliative care and so we'd started here at Duke about eight years ago, an outpatient palliative care clinic that's five days per week and we co-located within the cancer center recognizing that we could lean heavily on the support and infrastructure of the cancer service line to start and I'm now branched into non-cancer as well.

Arif Kamal: We operate that clinic five days per week and I attended in that outpatient clinic to see patients with cancer and non-cancer diagnosis and we've been very proud to see a mix of patients many of them quite upstream from end of life care. We have instituted ways to really increase referrals around the time of diagnosis across various different cancers.

Arif Kamal: I think my other role too is within... as a health services researcher is trying to think like a lot of researchers in our field about how to solve problems and to use the right methods to get after them and so for example one of the areas that we do researches patient and clinician facing mobile app development and the team that I work with, we put our heads together a few weeks ago to try to understand how do we increase people's reflection around gratitude and the positive things that are happening particularly in light of all the negative news that that continues to come out and so we started thinking about how to develop tools and strategies so that our colleagues have better ways of doing what they're doing on the front lines to take care of patients, particularly inpatient setting and being sort of more emotionally healthy in doing that.

Lynn McPherson: Anything new on the horizon from that effort?

Arif Kamal: Yeah. It's great. I love my job in the sense that one, I work with a really fantastic team and two, being in palliative care means that we have a really great view from the nest, right? Imagine an eagle's nest at the top of a tree. Palliative care is in many ways kind of up there because we get to see many components of how a health system runs. We get to interact with many different clinicians, with people with various different professional backgrounds who have various

different stressors, both them and their patients and we get to see all the new and fancy things that come out as medicine continues to change.

Arif Kamal: Up from that eagle's nest, one of the things we saw is that there's an opportunity to develop and disseminate an app that can help our very busy and stressed palliative care clinicians and frankly other clinicians as well. Journal their gratitude for the day, which there's very robust evidence to demonstrate that journaling of gratitude, even three simple things that one is grateful for, happy about, or experienced something that went well, that by journaling that every day and then importantly, sharing it with others that you care about and who you want to share it with can be really helpful to address depression and anxiety and also build resilience, and so we started working with a partner here in the Durham area, a company called CrossComm to put pro bono work together.

Arif Kamal: I mean, the beauty of a lot of very passionate people is you can start putting them into teams and over a short period of time have created a web app that's called the [Three Good Things 00:04:20]. In fact the website is [thethreegoodthings.org 00:04:24]. It's a free app that anybody can use to jot down three good things that have happened that day and that they can create a closed group like you and your spouse, you and your family, you and your friends. You can invite people to join that group and share those three good things with them every single day and importantly-

Lynn McPherson: [crosstalk 00:04:45] is it open and readily now. It's available now?

Arif Kamal: It's going to launch within the next couple of days. So yes, very soon.

Lynn McPherson: Okay. Great.

Arif Kamal: We are working very quickly to get it out.

Lynn McPherson: That's wonderful. That's great. Well, you certainly shoot me an email when that's out and we will help you promote that. It's a wonderful idea.

Arif Kamal: Thank you.

Lynn McPherson: I should mention that you said you're a health services researcher. Dr. Kamal is our course manager for our course [PALC 616 00:05:09], which is research outcomes in palliative care. That's been a fun experience. Hasn't it, Dr. Kamal?

Arif Kamal: It has. It's really neat to see people grow and learn from being anywhere on the spectrum of being frightened by research to maybe anxious about the concept of research to start to be comfortable, and I think as any researcher in palliative care knows, sort of the more you learn the more questions you have about how to do things different, better or more rigorous. Research is a lifelong journey of learning and of answering questions and recognizing there ae more questions to

ask and I think for students, what they've enjoyed is that systematic investigation. Which broadly speaking is a lifelong skill both to improve but also is usable even if you're not a researcher.

Arif Kamal: Systematic investigation is the same approach we take for quality improvement as well. Right? The difference between quality improvement with a lowercase q and a capital q is that in lowercase q, everything is quality improvement, right? Getting your puppy trained is lowercase quality improvement and getting to work on time is lowercase... anything. Getting an EHR to work a little bit better is lowercase quality improvement. Uppercase quality improvement is the hard work that oftentimes palliative care clinicians and administrators and leaders are involved in. It's the hard work of actually driving sustainable change to improve clinician and or patient or health system outcomes and that requires systematic investigation, right? A systematic approach to making changes and systematic measurement to see if those changes are working.

Arif Kamal: I think what we really focus on is not in the course, not building future researchers. For many people that's not their goal, it's giving people the skills to be more thoughtful thinkers, critical appraisers and more engaged leaders for their organizations to be involved in doing research or reviewing research or being part of a leading quality improvement. So for example-

Lynn McPherson: Well, you know, you mentioned you're doing research. One of your students, or I can't remember which section it was, emailed me yesterday saying my professor in this course wants me to consider what could be a weakness of a study. What does he mean by that? And I said, "Well think of what's going on now with the hydroxychloroquine situation. Are there any weaknesses to that data?" What would you say about that?

Arif Kamal: Yeah. I posted that exact article actually and my wife who's a pulmonary critical care physician and I did a mini journal club in our house, which is not a reflection of most of the nerdy things we do after we put our kids to bed. It's not generally our conversation, but in-

Lynn McPherson: [crosstalk 00:08:17].

Arif Kamal: Yeah. In the moment as times are, it requires us to be quick interpreters of lots of data that are coming our way and we do that naturally with everything else that happens, right, is that we have to... oftentimes we're given a deluge of information, right? There's no lack of information and the hard part of what we have to do is interpret it and find meaning, and the same thing happens with research, right? There are more research articles published every day than any human could ever read and so one, we have to find the ones that are applicable to what we are interested in or do, but secondarily we have to be able to critically review it and find the meaning in it to understand if there is meaning in there that is applicable to me.

Arif Kamal: For example, there was the paper that I posted to the class and I said, exactly, tell me what you think are the weaknesses of this article and the article is the use of hydroxychloroquine plus or minus erythromycin in patients who have nasal pharyngeal swab, PCR positive, COVID-19 or novel coronavirus on day one of a hospital admission and then it was compared to controls and the primary outcome was the PCR status at day seven without giving the answers away to the students, but I think they're going to figure it out because the things we've been talking about is the control arm. Funny. It's not balanced in any way in terms of sample size or in terms of characteristics.

Arif Kamal: The study censored or essentially did not evaluate the outcomes of patients who are randomized to the intervention, but then who worsened and went to the ICU so it was not an intent to treat analysis, which in a drug trial is a huge no-no. Essentially what my wife and I did is we re-ran the stats with the data that they had and came up with a different conclusion than what the authors did. We're going to use that opportunity in our class to not make a clinical decision about the utility of Plaquinel and novel coronavirus but what we will talk about is, if you were to design a study, would you have done it that way? Right.

Arif Kamal: When you read this paper, does it convince you and why or why not that you would do the thing that it concludes, and importantly, as an author, would you... or as a reader, would you push the authors to give you those clinical outcomes because the outcomes that were reported were not clinical outcomes now that the paper is more than three weeks old, right? As a member of the scientific community, should we email those authors and say, well, I'd love to know what happened to the people. Did they get better? Did they get worse? And so on.

Lynn McPherson: So [crosstalk 00:11:24].

Arif Kamal: Exactly, and that's the kind of growth we're looking for from the students to really sort of critically think. Even if you're not a researcher, the point is, you are asked to... as a medical professional, as a healthcare professional, as administrative professional, you are asked to interpret and evaluate data that comes out and to make conclusions about whether it's appropriate for your patients or your institution or best for even you, and that's the types of skills where we're trying to get across.

Lynn McPherson: And meanwhile we have Washington sitting on 29 million doses. That should be interesting. Well, I do know in this course of all the courses in our program, if you look at the students' feelings going into the chorus and coming out of the course, we see the biggest tremendous change with discourse because they really are quite trepidatious about this course but then they're so proud by the end at what the course manager yourself is able to pull out of them and to learn about a health services research. So thank you for your good job on that, but

let's circle back to what you do in palliative care. In your outpatient clinic you have multiple disciplines present I assume?

Arif Kamal: We do.

Lynn McPherson: That's it.

Arif Kamal: And are continuing to build that team as we do the hard work as a lot of other teams do as well to demonstrate the value and the return on investment of the health system making investments of other interprofessional members. It's a constant opportunity for us to address and we continue to push forward to expand our team because we believe we're better when our team is more diverse.

Lynn McPherson: Absolutely. How has both your team and perhaps Duke's inpatient palliative care services changed in the face of this epidemic?

Arif Kamal: Yeah. In many, many, many ways.

Lynn McPherson: Sure.

Arif Kamal: One, I'll start on the outpatient side. We have moved the 95 plus percent of our outpatient palliative care encounters to being telehealth, meaning either via telephone or telephone plus video, and we have in that process, both recognized the logistical complexities of doing that, the care coordination complexities with doing that, and sort of the disparities that start to arise when we do that. First related to the logistical complexities, we have to reach out to our patients and both demonstrate a sense of concern and care for them and a sense of calm that says we are doing this for your best interests to see you over the phone or via video but this is not a state of panic.

Arif Kamal: And I think when patients are very busy thinking about already so many things related to their own serious illness that when we layer this on top it's very important how we message to them that we are looking out for their best interest, one and two that this is temporary, that we are not a fundamentally changing the nature of our therapeutic relationship. That we will continue to remain high touch but for now this is the best way to be able to do that and to keep them safe.

Arif Kamal: Regarding care coordination complexity, as I mentioned, many of our patients are cancer patients or they are transplant patients or they obviously are seen by other specialists and we're trying to do this dance where maybe they are coming into the cancer center to receive their chemotherapy labs and scan, but their oncologist is going to talk to them via phone. So even though they're in the building, the oncologist may be in the building, they have decided together that to reduce the face to face person to person exposure risk, that the actual

consultation will happen via phone while for example, the patient and their caregiver are driving back home after the labs.

Arif Kamal: And as palliative care consultants we are trying to follow the lead sort of doing this tango and then letting the oncologist or the referring clinician sort of lead the dance and we're trying to make sure we fit in well so that we're not asking to see patients face to face when they're not and vice versa. In the same way the oncologists are seeing them face to face, we're trying to really be thoughtful about whether adding face to face time with us is one plus one equals three or whether we can also do that via phone.

Arif Kamal: That's sort of the care coordination complexity, and then lastly is sort of the disparities that we start to uncover. As you recognize when we do telehealth, for many of these patients it's better or ideal or preferable to not only do a phone call but do it with video so we can see the caregiver, we can see the interaction between the patient and caregiver. We can try to assess emotion and when you turn on video, you get a peek into the patient's world, which is their home and how they live and you start to get a sense of who else is in the home and how those interactions go and then you also get to see when they say, oh, I've got this little Boston terrier named [Fluffy 00:16:34]. You get to see Fluffy, which is also a nice thing as a palliative care clinician.

Arif Kamal: But we also start to recognize that by... we require that people have technology and Internet access and the ability to have secure video conferencing platforms and apps and we start to uncover that there is oftentimes not only challenges related to health literacy but also technology literacy as well as access to some of these things, and for many of our patients their vulnerability is not just the fact that they have a serious illness which is challenging their own resilience and their bodies, but also they have this psychosocial vulnerability which has to do with sort of the environment and how they live.

Arif Kamal: We're trying to equalize some of that by thinking about different ways that we can use free software and other things to try to make that easier, but also recognizing that moving forward from the pandemic, one of the lessons we're going to learn here is that there is not equity in terms of access for all of our patients for these times of just-in time interventions. For us telehealth is a just-in time thing but we have to be more mindful. On the inpatient side, I feel for my colleagues. I don't do inpatient medicine right now, although I think every clinician in the country is in some state of being part of a backup plan, a search plan or being plan B or C. I am one of those clinicians as well.

Arif Kamal: What I'm hearing from my colleagues both here and across the country is that palliative care is one increasingly being called upon and accepted and valued in a way that maybe had not been felt before. I think for certain forward thinking organizations that have really dynamic palliative care programs that have been around for a long time, maybe that had not been the issue, but I still think for the majority of programs there is a sense of we need to prove our value to

remain sustainable here. It's not inherent that everybody understands that we are more than an end of life service.

Arif Kamal: The good news is I think in our experience and I'm hopeful for many other programs' experiences that the majority of patients that are being evaluated for COVID, enrolling in for COVID are not going to die, which means that the fundamental intersection between palliative care and patients who are COVID positive and being ruled out is that we're not going to be talking about exclusively end of life issues. Now, we will be talking about hoping for the best and planning for the rest and naturally the rest can involve death. It can also involve debility. It can involve financial worry and other things. So there's a lot of things to talk about.

Arif Kamal: We also see that in a moment like this, there are a lot of concerns around medications and interactions and should we be doing something and treatment interventions and so on that patients and families have. There's a lot of uncertainty around outcomes meaning, well, nobody's particularly immune. Risks are higher or lower in particular populations and age groups, but nothing is a hundred percent certain so how do I think through that. Palliative care clinicians are very adept at working through that, and then also sort of planning for the things we can't see or know.

Arif Kamal: Oftentimes one could take a spiritual context in terms of thinking about acknowledging things you can't see or prove or know that it exists. In the cancer context, we certainly talk to patients about that. For example, when we do a scan and they say, well, Dr. Kamala, the last scan I had showed no cancer, why is it now three months later, my cancer is back. We have to talk about essentially planning and this is why, hopefully we'll have intersected with those patients early on where we have again, planned for the things that are unanticipated and frankly unwanted but that we planned for them in a way so that people have already started to think about scenarios that are uncomfortable, scenarios that you cannot see because they may be too far or too small or too uncomfortable to think about.

Arif Kamal: And so COVID is an example of where we are being called upon to do that kind of planning. Now, the day to day challenges are this, colleagues across the country are facing situations where we are doing consults in patients where we can't go in the room.

Lynn McPherson: Right.

Arif Kamal: Because we are trying to reduce risk and preserve PPA. We are watching and caring for patients who are dying of COVID for which the family is limited in terms of their ability to be at the bedside during the time of death. That families are, if they're able to watch that procedures to protect families and staff from aerosolization during the process, for example, of a palliative extubation. That in fact for many organizations, they're not taking the tube out, which oftentimes

would be our practice right around the time before a death and so patients' families are having to see kind of all the equipment and everything in the room from a distance while their loved one passes. That's a challenge.

Lynn McPherson: Oh, my goodness.

Arif Kamal: We're also finding right that when patients' families cannot be at the bedside and not more than one of them, for example, is our policy can be in the room upstream from death, that having advanced care planning conversations oftentimes are being done over the phone virtually and trying to bring multiple people together through phone plus video conferencing plus one person's in the waiting room and so palliative care is playing an important role of coordinating all these people to, again plan for the best and hope for the best and sort of plan for everything else.

Arif Kamal: And I think the other role of palliative care is also playing in the midst of uncertainty because frankly as a field, that's where we are comfortable. It doesn't mean that we like it. It just means we know what that's like. It's like when my children insist in April to go to the beach, I know the water's really cold.

Lynn McPherson: This is great.

Arif Kamal: I know it's going to be uncomfortable. They know it's going to be uncomfortable as well, but they are okay getting into it. It's that experience that starts to bring some sense of wisdom in this and everybody's walking around. Patients, caregivers, people, clinicians are walking around with this great sense of uncertainty and what palliative care clinicians are not only being asked to do is to address the uncertainty on the patient and side but also on the clinician side.

Arif Kamal: I think we sense a real feeling of anxiety and worry. It's palpable. You can see it in people's eyes and those are the same eyes we see when we've talked to patients for decades and now we're seeing it in our colleagues, and we see the opportunity to debrief with them and demonstrate our humanity all together to try to get through this so I think... that's the other thing, is palliative care is both being asked to provide clinical care, but also take care of our colleagues. That's an important responsibility. One where it's set up to do well, but also one that is a challenge, right? We can recognize that we're good at it and also recognize that yet we'd rather be doing something else at the moment.

Lynn McPherson: Of course. I think the whole profession is very fortunate to have palliative care. Of course, I would think that. That's what I do too but I think that's a tremendous service, and it occurs to me that as you speak about families, maybe one person watching from afar as their loved one dies, there must be a lot of grief and anticipatory grief floating around. How are you dealing with that? Have your local hospices been of any assistance or how are you dealing with that?

Arif Kamal: Yeah. We've brought a lot of visibility to the bereavement services that were already in the hospital, but oftentimes sort of thought as being that palliative care was the gatekeeper into that and now the bereavement professionals are really stepped up and this is their moment where a lot of other clinicians who ran the gamut from not even recognizing they're there are available to now understanding that there is a true sense of anticipatory grief and the bereavement is real and also affects clinicians as well. That there's an opportunity to address that.

Arif Kamal: Hospices have done a great job, particularly in our local area have done a great job stepping up to that. They are also facing very unique challenges, right? Again our challenges start both with workforce. You imagine a well oiled machine works really well until one clinician starts to demonstrate symptoms, and because then you're challenged with all the clinicians, other clinicians that were around that clinician and so now you can go from a workforce that was fully staffed in a well oiled machine to within a matter of hours being highly stressed because maybe a handful of clinicians now have to go home and so you went from having right and interprofessional, highly effective multidisciplinary team to we have one nurse now, to we have one pharmacist all the nurses went home. That's a challenge from the workforce side that applies to palliative care or hospice. Applies to all medicine right now.

Arif Kamal: The other thing is hospice care, right, is for most of our patients are at home and so being very demonstrating compassion and concern and the ethos of what hospice is, which is we're going to take care of people where they are both sort of mentally, emotionally, spiritually and physically in their own home. Now recognizing that being in a patient's home can be a threat to our own workforce is something that the field is having to balance and I think each organization that I've seen and heard from is doing an amazing job and working through that both demonstrating compassion and concern, but also keeping a little bit of physical distance that's required to be safe both for the patients and their families and for our workforce as well.

Lynn McPherson: Sure. I have seen locally our hospices have stepped up significantly in terms of dealing with the anticipatory grief that families are experiencing prior to their loved one's death as well as after the death, even though they didn't actually provide hospice care to the patient.

Arif Kamal: Right.

Lynn McPherson: Often we'll see hospices do like for suicide victims and so forth.

Arif Kamal: Absolutely.

Lynn McPherson: I guess as a pharmacist, I have to ask, how has the drug shortage affected what you all do, particularly with vent withdrawals?

Arif Kamal: Yeah. We have been a little fortunate here from our supply chain perspective that I... I think we stayed ahead of that a little bit, but we're also having to be creative in a lot of different ways, not only because of potential shortages but also because of the practicalities of having people in and out of rooms that are COVID positive. Look, we might in another scenario provide unfractionated heparin for VTE prophylaxis, but we're going to weave, for example, [inaudible 00:28:48]... so in our practice moved to once a day low molecular weight heparin for the purpose of providing adequate prophylaxis but reducing the number of times that a clinician has to walk into the room.

Arif Kamal: We're also cross training clinicians who are not used to hanging or administering medications to doing that. Because what's happening now is every time a clinician walks into a room of a COVID positive patient, it presents a risk in both directions really. It prevents a risk of secondary nosocomial infection for the patient who is battling COVID within the room. Also presents a risk to the team member who's going into the room, which means that our teams are doing a huddle before a clinician walks into the room to understand, can we batch things like batch medication administration.

Lynn McPherson: Sure.

Arif Kamal: if the physician's walking into the room to do a physical exam, can we have the physician administer the medications, hang a bag, start an IV, do that kinds of thing. So what's amazing to see is that nurses are training physicians to do things that they have either barely learned in medical school and have not done since. Pharmacists are training nurses about creative ways to administer medications through potentially longer tubing where the tubing's coming out of the room so we can actually administer outside of the room.

Lynn McPherson: That's crazy.

Arif Kamal: ...but still go in and now we've got doctors doing things too... What's amazing to see is the collaboration and camaraderie that's coming out of this. This is not, well, this is a doctor's job. This is a nurse's job. This is a pharmacist's job. Right now this is humans taking care of humans and what's beautiful to see is that natural breaks that come from hierarchy and sense of, well, this is my job and this is your job and stuff. All that seems to have melted away because everybody's now mission-driven and that's been fantastic to see.

Lynn McPherson: Yeah, under sad circumstances that finally and brought this about though, huh. Do you think that we are providing good self-care. As palliative care clinicians, as all the professionals out there, aside from your three word gratitude thing, which will be greatly welcome I'm sure. Do you think we're doing a good job of taking care of ourselves and each other.

Arif Kamal: Yeah, I worry about that a lot. In some of our work and some other folks' work as well. We really recognize that isolation either geographic or perceived,

meaning that you live in a rural spot or you are on a team that has a team of one, or that you feel isolated. You are used to working on an interprofessional team. Normally four people would go in the room to do a palliative care consult and standing on your left is your very experienced nurse practitioner, standing on your right is you're very experienced pharmacist, standing behind you is a fellow who's really keeping tabs on lots of details and right behind your right shoulder is a chaplain and you're this team, you're this force.

Arif Kamal: And now what we're doing is we're saying, well how can we keep the teams as skinny as possible so that we reduce risk? So maybe your team isn't that force of five people anymore. Maybe your team is now a force of two and you're splitting up to do consults so that the other folks can stay a little bit protected, provide consults and advice over the phone, but there's not that sort of kind of social proximity, physical proximity, that means we're a team and we know that feeling part of a team is protective, and so I worry that the high anxiety, the high uncertainty that we're good at, but look, standing next to a waterfall thinking you're not going to get wet, right?

Arif Kamal: We're all standing next to Niagara Falls right now and we're standing very close emotionally, maybe physically it feels like we're staying a little bit further, but actually we're emotionally very close. That you can't stand next to Niagara Falls and not feel a little bit of some water droplets on your face and I worry that that's what's happening. I also worry that in the sense of busy, when people get busy, situations get complex, stakes are really high. That oftentimes leadership styles can seem to transition away from what I think palliative care is or used to, which is collaborate and conquer. The palliative care teams lead by working together and solving problems, collaborate together, conquer the problem.

Arif Kamal: That in situations where there's high stress and high stakes, that sometimes health systems, clinicians, organizations revert as a protective mechanism to a command and control type of leadership style, which is not a critique. It may be exactly what's needed for that moment but I also worry that command and control to people who are used to sort of collaborate and conquer can feel awkward, right? Can feel rushed, can feel not like there's a shared pool of meaning. It can start to feel like that it's very hierarchical and one way and that kind of thing. I also worry about palliative care teams just sort of kind of functioning in this very different environment in terms of how decisions are made, how conflicts are resolved, how teams are working together not just their own team, but also just healthcare teams in general and when thing-

Lynn McPherson: So any suggestions for that? To deal with that.

Arif Kamal: Yeah.

Lynn McPherson: Aside from just being aware.

Arif Kamal: I think there is more need than ever for palliative care teams to debrief and to... because the nature of communications right now are really about problem solving and palliative care folks are used to walking into situations they can't fix. They can be present, they can help, but they can't take away. COVID-19 has shifted a lot of communication within health systems to fixing problems. We're short on masks. What are we going to do? We're going to recycle them and decontaminate them. We are worried about visitors coming, bringing it in. What are we going to do? We're going to shutdown doors and we're going to do screening for people who walk in the building, right?

Arif Kamal: There are problems and there are problems to be solved and that's sort of the nature of most communications right now. We have to take the time as a feel to remember to be in a room together where we're not trying to solve a problem. Where we are reflecting, acknowledging, holding the fact that this sucks right now and it sucks as individuals. It sucks as family members. It sucks as being a community member. It sucks in a lot of different ways and that we are all feeling that. There's a shared experience here and that we can talk through it, not to solve it but to understand that each other is also struggling and in that there is power.

Arif Kamal: We have to more than ever make sure that our team members are doing that. Second, I think we have to remember palliative care is a very mission driven specialty. Half of our workforce particularly among physicians, started out doing something else and then came to this field, right? That means that for many clinicians, they took a pay cut, they sort of switched their path which might've been to excel to the next ladder, to the next step, to the next step, to the next step, and kind of got off that ladder to another ladder and said, I don't even need a ladder. I just want to be on the palliative care team.

Arif Kamal: With that comes potentially my worry that there is a sense that we are going to give everything we have for the goodness of the purpose, and I think there is an ability for sure to do that, but to not go home with your cup being empty, that we have to be self-preserving as much as we can, that we have to fill back our cup by doing nonmedical things though the need is really high. I think in many ways we're all recognizing that we're actually running a marathon, not a sprint and so by expending all your energy in mile two is not helpful to anybody who's trying to get to mile 26, and so I think as we're recognizing that, that means, yeah, we protect some of our team members. We work in shifts, we share together our concerns. We remember that we're all human and we also acknowledge that being a hero during a time of a pandemic is not predicated on ignoring the fact that this is causing personal challenges, right?

Arif Kamal: Being a hero doesn't mean that you're fine with all of this. Being a hero means that you are doing the things to help other people when you're asked to do it, but you're doing in a way that says you're ready to come back tomorrow and the next time you're asked whenever that is, which means that you have to take care of yourself, and so in that sort of a balanced approach, I think you're

really... we're running a marathon here and I just want to make sure that our colleagues are really taking care of themselves, whatever that looks like, that they are taking moments away from the news and other things to focus on positivity and gratitude and recognize that in the moment now the sun did come up and here in Durham it's gorgeous outside.

Arif Kamal: The trees are coming out. I've got flowers in my backyard. There's a lot of things to be grateful for and be happy about and just like in everything else, challenges that I faced, the U.S., the human race, et cetera, we've gotten through them and we can be very hopeful that tomorrow will be better while recognizing that we can handle some of the challenges today, but that we need to lean on each other so we're not doing it alone.

Lynn McPherson: Absolutely. Beautifully said and should all go in your gratitude journal so-

Arif Kamal: It will.

Lynn McPherson: So good self-care and caring for each other, it's so important. Last question as we wrap up. As you look in your crystal ball, how long do you think this marathon is going to be? [inaudible 00:40:12].

Arif Kamal: Well, it's kind of like giving prognosis, right? I think we're in the weeks to month range. I think what we'll find on the other end of this is a greater appreciation for palliative care.

Lynn McPherson: Absolutely.

Arif Kamal: I think we'll find on the other end of this a greater appreciation for advanced care planning regardless of who is leading that conversation. I think we'll also find a greater appreciation for remote patient monitoring in telehealth and intersecting with patients where they are. We've been thinking about that in a lot of ways in terms of where they are mentally and spiritually and emotionally and physically. Now, I think we're going to find a lot more attention and where they are geographically and we'll start to recognize that the next crisis... I mean, remember most people celebrated Valentine's Day without COVID being one of the top five things on their mind and we are merely but 60 days from that point in time. So the world changed quite a bit.

Arif Kamal: It means that I think the role of palliative care and the role of how health care is going to be designed is going to be thinking a lot about how to rapidly respond and in prevention so that now, regardless if it's novel coronavirus or anything else, we're starting to recognize that humans are fragile things. We are fragile and that means that whether you're 29 or 79, having advanced per clinic... [inaudible 00:42:03] conversation is a really good use of time particularly outside of a moment of crisis, but I think everybody's now going to go home and when this is all over, look at their children, look at their grandchildren, look at their family, look at their friends, look at the people they care about and say this

probably going to happen again at some point and how are we all being best prepared for sharing my personal healthcare wishes making sure that people around me know what are my preferences and values and also recognizing when it depends.

Arif Kamal: It's kind of like when I ask the students in the research course, when you tell me it depends and I say this to my patients too, and I say this to my research team members, I say this to myself too when I'm driving and I say, well, at least it kind of depends. What does it depend on? The answer to that question reflects what's important to you because it depends is that first answer. What it depends on is the harder answer, and it really reflects what it depends on.

Arif Kamal: It's sort of the classic question. If the right thing to do is to be on a ventilator for you and that's your personal preference but sometimes it wouldn't and it kind of depends and then I want to know what does it depend on, and if it depends on where you're going to live after that ventilator is done. If it depends on what's the chance the ventilator is going to help you. If it depends on what that experience is going to look like. If it depends on what that's going to financially mean to your family. Whatever it depends on without any judgment.

Arif Kamal: I think what we, in healthcare, we in palliative care, we as people are going to learn from this is that the, it depends matters, and to answer that question requires introspection and I think there's going to be a lot of that introspection happening.

Lynn McPherson: Wow, very insightful. Well, we've been chatting with Dr. Arif Kamal, palliative care physician, and I'm pretty darn good thought leaders in so far as what's been going on with the pandemic and the role of palliative care. So Dr. Kamal, thank you so much for being with us today.

Arif Kamal: Appreciate chat.

Lynn McPherson: Thank you all for listening to the Palliative Care Chat podcast. Again, 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 requests regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.