

Dr. Lynn McPherson:

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

Connie Dahlin:

Welcome everyone to another one of our palliative PhD programs podcasts. My name's Connie Dahlin and as you know, I'm one of the faculty for the PhD program. I am joined today by Dr. Lynn McPherson, who is the Director of the University of Maryland Graduate Program Masters in palliative care. And we are joined today by one of our colleagues, Patrick Coyne. Patrick has been influential in palliative care in many ways. One in his role in oncology nursing, another in palliative program development, and then another just in terms of thinking about adding to the evidence-base of palliative care.

So currently Patrick is a clinical nurse specialist, assistant professor and director of the Palliative Care Program at the Medical University of South Carolina at Charleston. And he has had several programs that have been recognized by the Circle of Life Program through the American Hospital Association. He served on boards for certification for hospice and palliative nurses, and also on the Hospice and Palliative Nurses Association. He's been a Co-PI for many different research grants, and also really helped in terms of education because he's one of the original faculty for the End of Life Nursing Education Consortium. So Patrick, welcome to our discussion today.

Patrick Coyne:

Thanks, it's actually a pleasure to be here.

Connie Dahlin:

So I've kind of given an introduction for you, I don't know if there's other things that you would like to tell our students that have been sort of important to you along your career or kind of got you interested into this field of palliative care?

Patrick Coyne:

Wow. I think I got into palliative care before it had a name. And I remember working way back when as an orderly talking to patients on the night shift, and they were all suffering in pain trying to figure out why aren't we doing better? And that kind of was where I started. And next thing I know my thesis was on cancer pain management back in 1983 or four. And from there just kind of went into really finding everything I could about pain management, got an NIH grant which took me to specialized pain management. Life changes, ended up in the military for a few years running an emergency room as the hospice liaison officer. So still keeping things involved that way but also running an ER. And so really kind of questioning why are we doing things and how could we do things better? And I think that kind of drove me a little bit and got hired by VCU to start a pain service, which I frankly thought was really easy managing post-op pain, kind of boring. But back to cancer pain and the cancer center hired me to do pain management.

And over the years you learned, well I could get the pain controlled but now they're vomiting, or they're depressed, or they're dyspneic. And so started really looking at how do we do better with that? So started doing palliative care, like I said before it had a name at least that I knew, and had some great

oncologists to work with trying to brainstorm ways to do things. I think some of the things through the years that were important to me is I work really hard to get legislation done in Virginia for palliative education, which still exists. I got hospice covered, which wasn't covered in Virginia. And I think those were really important things. And I guess the other thing is I've really enjoyed teaching internationally in countries, so we worked to get morphine in Tanzania for the tumor hospital. So that was a lot of work back in the early '90s too, and I still like doing some of the international work.

Connie Dahlin:

So when you think about where you started to where you are now, are there things that you think are still current themes that we need to keep tabs on? Or do you feel like we've kind of moved ahead and there's other issues that we need to focus on?

Patrick Coyne:

No, I think boy, we've got a long way to go. A lot of our practice still isn't evidence-based so I think there's a lot of research that needs to continue. I think there are a lot of barriers to palliative care, and they're hospice barriers. None of the hospice are standardized so I don't know what hospice offers compared to another, which drives me crazy since I'm dealing with 20 of them. If I look throughout the state I'm dealing with more than 30 of them, and some will do certain things at home and others won't. How palliative care education is obtained in some medical, nursing, pharmacy, and social work schools. Some get an hour, some get 30 hours. So how do we get a baseline for understanding?

Because we know we're short so many palliative care clinicians, we're not going to get everyone through a fellowship or everything, but I think there's primary basic palliative care that isn't being addressed. And we need clinicians to be able to handle the 80% of easy pain management. We need administrators to understand why it's important and fund palliative care programs because they don't pay for themselves, but it's doing the right thing and it saves them money. But a CEO who's older doesn't understand spending money and not seeing RVUs or money come back. It's a new business model for them to think of cost savings, and that takes a ton of education and a ton of time.

Connie Dahlin:

Which you bring up that you should talk about and tell our students that you did some very important work in VCU of actually documenting this cost and could come out with an amount of money per patient. So talk a little bit about that and how much energy that took, but why it was really important.

Patrick Coyne:

Well, I mean that was a team approach. So there's Tom Smith, Brian Cosell, and a few others that really kind of looked at... We were under the gun by administration, like some head hunters came in or budget cutters came in back in, I guess it was 2002 or 2003, saying you need to save blank amount of money, cut palliative care because you could immediately save all the salary support you guys are giving them. But none of these people that came in and consultants actually understood what we were doing. And in fact they had never evaluated a palliative care program and they just saw you're spending money, we don't see how you're making any money back from them. And so we did in a week an incredible educational program for these budget cutters. And at the end of the week they said, you should expand palliative care.

But no one had looked at the cost savings, nobody had looked at patient satisfaction. No one had looked at days in the ICU, or length of stay, or readmissions for that matter. And so we had that

data that we were already working on trying to understand how we were changing care in a health system, and they just pushed us. And I'm not even sure CAPSI was real then, but it was early. And so a lot of other outside facilities jumped in and said, help VCU because they're coming our way next. And so we were getting resources, it was a great sharing of information among health systems very quickly to make our program survive. And I don't think the unit staff itself knew how challenging that week was, but we were probably doing 20 hours a day of work just to get this thing through to them.

And at the end we had the Wall Street Journal come down and say, let's do an article because this makes no sense. And our hospital gets nervous when, if Wall Street wants to do an investigative report on a health system it's usually not a good thing. So they were scared to death but they let it happen, and they actually mirrored our numbers, I mean within pennies of what we reported. And I think that just kind of took us off the fire and all of the sudden kind of showed this is important and it's the right thing to do. But we were at the, I would say the right place at the wrong time where we had to start demonstrating those things. And to be honest, if it wasn't for Brian Cosell, and Tom, and a few others who were at the table, I don't think any of us would have pulled this off.

Connie Dahlin:

And then you subsequently, I mean you did that for the hospital but then you also did that for the community for your office space. Which I think was another really important step in terms of demonstrating that worth.

Patrick Coyne:

Yeah, I mean I think it was important to demonstrate that the outpatient clinics were important, and that they served a purpose, and that if you could do it in community settings like we started demonstrating with CAPSI, it wasn't just academic [inaudible 00:10:37] that had these challenging patients. And populations change, and so I think we learned how to do that. And I think the CAPSI registry when it got established helped demonstrate a little bit more of that. The VA's clearly shown some data with patient satisfaction for sure.

So all those things I think are pieces that are important, but it's funny when you show cost savings you may make it a CEO really happy for a year or two, but they always want to cut budgets. And when a cardiac cath lab can bring in \$20 million and you're saying we're going to save you money but you're not bringing in \$1 million, they don't get excited. And every palliative care program is small, so you don't get a big voice at the table. So you got to make sure your voice is always heard, which is something I learned along the way is you've got to make point of meeting with the CEO, the CFO. They need to know what you're doing, they need to hear your stories.

Connie Dahlin:

But that's an interesting thing that you would that Patrick, I wonder do you feel like the voice of palliative care kind of changed over the last year with COVID? I know you were very involved with your health system. So in crisis times maybe that was an opportunity?

Patrick Coyne:

Oh, COVID clearly put us front and center. Which I find really interesting because I know hospitals had closed their palliative care program during COVID to save money, which I don't understand because we were drowning in work. It was terrible because there weren't enough people to make those phone calls to talk to families, to be at the bedside, to make sure the breathing was comfortable. I mean our group

went to seven days a week, 24/7 call because everybody was overwhelmed and everybody needed support. And I think all of a sudden the health system realized we had a major role.

We just recently went back to five days a week with 24/7 call coverage, and there was a lot of pushback going, how can you guys do that? Well there's not enough of us to maintain this, and remember when we asked for more people and you didn't want to budget it? Now it's time for you guys to think about we need more people because this is unsustainable. And in the COVID era let's be honest, who took vacation? Where are you going to go? What are you going to do? Our team's a family and I think it was [inaudible 00:13:31] together.

Connie Dahlin:

You've kind of set on the next point, and so I think for the students to understand working with people is really important. We have our family of choice, which is our personal time, biological family, nuclear family, whatever we choose out of work. And then when we're working it's really a work family. And people have different roles and you have to figure it out.

I think it's really important for you to kind of talk about your philosophy of teamwork, because I can say that I have witnessed you do this twice with teams that are committed to each other, that have a common theme of respect, and specifically in my mind what I've witnessed is that everybody's all in together. And so if you're meeting altogether, you're figuring out the day, if somebody's day falls apart it's okay to ask for permission, and the expectation of somebody's having a light day they're going to help out. And I think at the end of the day, which is what has always been impressive to me, is that nobody's lagging behind. Everybody is walking out of the door together. And I think that that spirit of comradery is really an important quality of leadership that you've been able to establish. So do you want to kind of talk about how you've worked with teams and kind of create that?

Patrick Coyne:

Well I think that if you don't understand team concept you probably have a hard time understanding palliative care, because the person with the most knowledge becomes the leader. So there are days I'm leading, there are days are social worker's leading, there are days one of our physicians may be leading because of the issue that we're dealing with. And so I've got the title but I don't need to lead if someone has more knowledge. So our chaplains leading the bereavement program, why would I lead it? She knows more about it than I ever will. And I think we also know if we lift together it's an easier job for all of us. So we all lift together. So somebody's sick, sickness happens. It's not like, oh, they're out again. It's like, okay, she's having a rough week. We all pull together and it's going to be a better week for all of us and for our patients and families.

And it's the philosophy that everything impacts everyone else so you take care of each other. So yeah, I don't want someone here at 9:00pm at night and someone else leaving at 2:30pm in the afternoon. Unless they have to be at their kid's graduation, then we're all here at 9:00pm at night. All of this is, and the expectation is I'll help you, you help me. But we work together and I think everyone has to have, someone taught me this a long time ago, when you start a program or in you're in a program, you got to have a mission statement and you got to have values. And everyone's got to have the same vision. And if you don't how do you get to the place you're going to if everyone thinks it's different?

And we talk about that all the time, and during COVID it was a major discussion. And when you're looking at the population you care for, annually we talk about that. Should we be seeing sickle cell patients? Well they have a life limiting illness, but do we have the bandwidth to give them the care that they need? And so these discussions go back and forth all the time on how do we do the best we

can? Because if we stretch ourselves too thin then we're no good, but we're also leaving someone behind. So how do we make that work? And it can't be stagnant, it's got to always be looked at.

Connie Dahlin:

And I think I know from my past experience with some of the programs that I had, when I would say, what is our mission and vision? They would poopoo me. And I was like, okay. So then we adopted whatever the sound bite was for our palliative care program brochure, which is never a good idea. And you still have to go back and do that. So I think that if you don't do your mission and vision upfront that's a problem, but I also think the other part that you were talking about is I think sometimes there are palliative care teams that everybody is pretty much working from beneficence and trying to work together, but then somebody will decide to take an exceptional case. And they don't understand that that's not a one-time thing, because once you do it you've set a precedent because everybody will say, well you did it for them. And so this understanding that we have to be really thoughtful about what special means, because it does impact the rest of the team.

So I think about when I started our outpatient palliative care program, we were in the ALS clinic and in the oncology clinic. And the oncology clinic was actually easier because the oncologist really wanted to still have full kind of, they really just wanted us to give them suggestions, and so we weren't kind of taking over care at all. But the ALS team wanted us to take over the care of the patients when they were admitted into the hospital. Well that had implications for who was on call for the weekend. And one of the things with our team was that the advanced practice providers were on call for the weekend, I started that as sort of stepping in to help out the team.

But that started a whole discussion because if I was okay with it, okay, I'm a seasoned clinician. But we had new APPs who are stepping in who were not comfortable. And so we had to have a whole other discussion about what does that mean? How do we get them to feel comfortable, because they're going to be covering and all that? So I think sometimes people feel like they're doing something good, which is great, but that you do have to check back with a team to make sure that that special case doesn't have other implications.

Patrick Coyne:

I mean yeah, I think that's tough. One of the biggest problems that I found mostly with physicians, especially new fellows, is they've never worked with a team and they're not used to people jumping in saying, I can help with that. Or, why don't you look at that? And so that's one of the biggest feedback I've gotten from our fellows, is it took me weeks to understand I'm working with others. And I think you have to kind of get people comfortable with that, knowing that you don't have to do everything, there are other experts to help you, and you can learn from them. And so we learn from each other, our rounds every morning we're running through, like this morning we ran through 44 patients. Some need one-liners, others need input from everyone around the table because they're complicated. And that's our group sharing, and it's a little bit of our debriefing.

And then our staff meetings are always meant to be, what are we doing well, what did we fix? And so I think you have to put things in place really upfront, and I think the one thing is talking about the patients brings everyone together. And it's a reminder to everyone I may only have three patients, but I'm going to be... I mean yesterday I spent three hours in the ER, ended up being more like five. But everyone understood I just couldn't get out, it was a disaster. And so numbers don't matter, because I can also see three patients in the ICU who are intubated, unresponsive with no family, and I'm making sure they're comfortable. I can do that in 15 minutes. Versus a bad car crash in the ER nobody saw coming with the family. So all of that is going to be a different consult.

And so some programs look at numbers, and you can't. So I think when you round you understand you've got five patients that are going to be horrible to get through it, they're going to be rough patients. And I may have eight patients that can be very easy to take care of, that are all going home with hospice, families on board, everyone's singing kumbaya, and it's not a bad day. So how do we spread the mix and make sure we're covering each other?

Connie Dahlin:

Well I think you also bring up this other part of like, if you're going to be in the ED. If you make that decision, which I know you and I have had a discussion, so for students to understand, being in the ED really means that you've kind of made a decision to affect care very much upstream. But if you do that then you have to make those consults a priority, because it is the emergency room, they cannot wait. When they're calling you, they're calling you for a reason. And you're either going to start the process that in fact they can go home from the emergency room, so maybe they go on a 23 hour observation area. They're going to get admitted to the floor and your palliative care team is going to take over so that again, you're streamlining them through the ED. Or in fact they're going to die in the ED and you're going to help that happen.

The last one is never my best choice, but it does happen. I remember for awhile that we had a rash of several hospices that were sending people to the hospital at the very end and they died. To me that's a failure unless we've had a discussion or something acute has happened. But talk a little bit about your thoughts about the ED and why it's so important for palliative care teams to really make that commitment.

Patrick Coyne:

Oh, ER is critical. I mean if we have new consults ER wins, because you're impacting care as you mentioned from the second they enter the door, and so you can start pain and symptom management so they can have conversations. You can talk goals of care, so do they really want to be intubated? Or if they do get intubated would it be a time limited trial? So would you like to try this for two or three days? If they're not getting better should we come back and re-explore? You're clearly introducing the idea of palliative care on its role because we're not just clinicians. I've got social workers, I've got chaplains, I've got volunteers who can help you and your family. So how do we meet all of you and your family's needs? So there's a lot you can do there.

And really is there a way to get them home, back home with hospice? If they are going to the ICU, the ICU knows you're already involved so you're partnering in care. Or do they have to go to the ICU because the family said or the patient said DNR, but their pain's still out of control so we've [inaudible 00:24:31]. So all of the above, how can we do all these things? The ER is very work intense, but you can change the entire hospital experience if you meet them in the ER. So yes, I love going to the ER.

Connie Dahlin:

It is fun. Sometimes it's a little like going okay, this is what they live in every day.

Patrick Coyne:

In my group it's kind of fun. Everyone has little niches in the ER, but we have some that really love cardiology, some like geriatrics, we've got one that loves [inaudible 00:25:06] oncology. So I mean we have [inaudible 00:25:09] group.

Connie Dahlin:

Yeah, I think it's a good thing to kind of think about where people like to be and help them, because then also those floors get to know them as well. I'm going to switch a little bit because I know Lynn will love this part of thinking about, you've done some interesting research studies. You did nebulized fentanyl, you've done some ABHR suppositories. Talk to people about doing those when it may not be a randomized control trial, it might just be a small piece and sort of how did you kind of start doing that? And what's the role of palliative care teams to do with that?

Patrick Coyne:

I never thought of myself as doing research. So I guess I love asking the question, why or why not? So the nebulized fentanyl, it was just me sitting down thinking about how could we get dyspnea control quicker? And I'll be honest, this was in an era before there were picc lines and it took two days or three days to get a port a cath in, and IV access in a 89 year old lady who's [inaudible 00:26:18] didn't always happen quickly. And hospitals don't like using subq, so I mean there were a lot of things. And when you're dyspneic... So I started thinking about fentanyl where it was lipophilic, it should be absorbed relatively quickly, and if we start with the low dose. And I saw one line in one textbook saying some people may think of fentanyl as a potential inhaled source for dyspnea. And I can't even remember where it was, but it was somewhere back in the '90. It was an English textbook, may have been Oxford. I don't know who it was, how's that?

So I started thinking and I was working with a great oncologist Tom Smith, who kind of said, well we should try this. And so we tried it on three patients and all of them said, I feel so much better. And three patients became 20 patients, 20 patients became 40. And we kind of said, we really think this works. So the first thing we did is we went back and we looked at 60 patients that got nebulized fentanyl, and if we had enough data we looked at respiratory rate, we looked at O2 stats, we looked at side effects, we looked at patient satisfaction. And we started asking those questions and retrospectively went back. We had to throw away a lot of charts. And when we did the original study included patients with AIDs, but when we published it they just wanted cancer patients so we throw out probably about 15 or 20 patients, which made it really stronger. But in the 80% that it helped respiratory rates went down, satisfaction was high, O2 stats got better. So we wanted to do a prospective study.

It took us five years to get through the IRB because they said it was a frail population, because they had a terminal illness, because we were saying we're using it on patients with like [inaudible 00:28:34] disease. And so for five years we rewrote the study, Tom and I, more times than I can tell you, and we could never get it through IRB. Finally IRB let it go through, but they put some of these stipulations on it that we can only enroll three patients. I mean it was incredible. So we gave up, to be honest with you. It's a generic drug so nobody was going to underwrite it. And then I saw Deb Dudgeon did a study with COPD and fentanyl nebs, and their exercise tolerance went up. Well that made good sense. I was like, go, you go.

And when I got here in South Carolina nobody had used fentanyl nebs. And so it was like, show us, we got to do something else so we did another retrospective study. The results actually mirrored the study we did back in 2002. So we tried to do prospective, can't get money funded for it. For the IRB pharmacies we would need like \$25,000 to do a study that I think should be done because I'd love to be a blinded prospective study, but I can't get funding to do it. I've got the study written, in fact Tom has the study written at Hopkins and nobody can get funding.

But I'm going to tell you my favorite research study. So there's a thing called scrambler, and it's electrodes that treat neuropathy. So this guy comes to me, he has this blue box, weighs 50 pounds. He brings it into the palliative care unit, he's talking about how it really works well, read all this data from

Italy. And he goes, we want you to be the first place in the United States trying this, we'll give you the machine. And so I'm sitting there and go, well I'm willing to listen. He plugs it in and it starts smoking. We have to unplug it, it doesn't work. And so I called Thomas, we got to do this study just to show this thing is a bunch of no goodness.

And lo and behold, he brings in the machine and we train someone, we do it, and everyone's getting better. I mean it was just like, we were so convinced this would not work. And we ran 20 patients through and I think 18 said it was the best they felt in years from chemo neuropathy. And we went and did two more studies with it, one on failed back surgery, another one on neuropathy, and the results keep coming back good. So sometimes my hypothesis fail, but it was a fun study because I really went in there to fail. Sorry, I just got... To show it didn't work and it did. But we just did a thing on existential distress, which was fun with our chaplains, looking at a tool for looking at that. We've done, I mean I always like to ask why. I did a sickle cell study looking does temperature impact crisis? Because every sickle cell patient used to say when it's cold I go into crisis. Well I said, well we got a study that. And it turned out it did.

Dr. Lynn McPherson:

Can I ask a question? Can I ask a question here?

Connie Dahlin:

Sure.

Dr. Lynn McPherson:

So I've been having discussions with people on my campus about, is research in palliative care different from just general old research? So when we do a statistics course or qualitative or quantitative research, would it be beneficial to tailor it toward palliative care? Because I do believe there are special considerations as you've mentioned in doing research in palliative care. What are your thoughts?

Patrick Coyne:

Absolutely. It's hard research because the patients you're working with are available for such a short period of time, and I'm not even talking about lifespan, cognitively. And it's such a burden to them when they agree to do it if they have to come to the hospital, nowadays you can do more with tele-health which makes it a little bit easier, but it's still I think a challenge that way. I think the other problem is that besides consent and a frail population they know their time is limited, and some are wanting to give everything they can to help others, and others want time with their family and I respect that. So it's a hard population.

And I could tell you what they put us through that gets me I think, the consent was 12 pages. I couldn't get through it and I wasn't dying. I mean I think we do make it really burdensome, and I think you have to look at it very differently because how are you going to get this research done to do the right thing or to improve the evidence because you give up? And I hate to say it, you get beat up. Five years again, beaten up. You just kind of say, eh.

Dr. Lynn McPherson:

Yeah. What do you think [crosstalk 00:34:04]. I'm sorry, go ahead.

Connie Dahlin:

Go ahead, Lynn.

Dr. Lynn McPherson:

I was just going to say what do you think about nebulized furosemide?

Patrick Coyne:

The data doesn't support it. And I've used it six or seven times before the last study and I never saw any benefit.

Dr. Lynn McPherson:

I agree, I agree.

Connie Dahlin:

Are there other things that you did studies on that you think I think were important or helped kind of with the field thinking about what was working and what wasn't?

Patrick Coyne:

I guess I bounced around the things that just interest me, [inaudible 00:34:35] study was kind of interesting to see if it helped with certain pain [inaudible 00:34:41] people procedures. And looking at lidocaine, our program at VCU took care of sickle cell, so I was seeing sickle cell patients everyday. lidocaine and ketamine, we did studies on that in people in sickle cell crisis, could we improve things? And I think those help but these are all case, these are-

Dr. Lynn McPherson:

Oh, I think the ABH studies, absolutely. You made the choosing wisely from the academy, and still to this day nurses swear by ABH or ABHR gel. I've even reviewed papers for publication where they said, I know that study by Pat Coyne and Tom Smith show it doesn't get absorbed at all, but my theory is you touch your face 17 times an hour, so it's the aroma therapy is your risk wafts by. And I'm like, I give you full points for creative writing but I'm not buying what you're selling.

Patrick Coyne:

The ABH study, it was funny because we just knew it wasn't, it shouldn't work but nobody would believe us. And I think we'd all lectured over the years and we finally just said, okay, it really shouldn't work, let's do this study. And we were able to get a small grant to do the first study. And I tell you what, I got booted off the stage. I was at the Pharmacy Association Meeting when I presented the original study. And there were so many compounding pharmacists that just, it was made wrong, had the wrong lectin, I mean the pH was obviously off. And they said, you have to do a study with cancer patients, you can't do it with healthy volunteers because it's different. So absolutely we went back and we did the study with cancer patients who signed up for it, which was also a nightmare [inaudible 00:36:30] get through IRV, and it failed, and also no blood levels.

Dr. Lynn McPherson:

Yeah. For our listeners, Pat, let's make sure we all know what we're talking about here. ABH gel is Ativan, Benadryl, and Haldol, and sometimes people throw in R for Reglan. And the thinking is if you apply it to the inner aspect of the wrist four times a day that they will treat nausea. So my first

contention is aside from cancer, what other disease or symptoms do you say let's try four different drugs at one time, and let's throw them all against the wall and see what sticks? It's ridiculous. And what Dr. Coyne found was that the Ativan and the Haldol didn't get absorbed at all, and the Benadryl was severely sub therapeutic and highly erratic. So there's no way in the world, if it doesn't get absorbed there's a good chance it's not going to cross your blood brain barrier and get to the vomiting center. Is that a fair assessment?

Patrick Coyne:

I think that's the great assessment.

Connie Dahlin:

Well, the other part though is, when I was doing hospice it was the suppositories, right? So they might get absorbed, but I think of thinking about again, every single one of those medications for older adults is on the Beers list. So then when something doesn't work and adjust, you have no idea how you're adjusting it and you're still throwing on four drugs. In my mind it was similar like, well if we're going to do that let's just put a Thorazine suppository and put them out. I mean what are we doing? But I think it's really interesting when you get some of the hospice orders and those are still on them. And as a clinician in best practice, I am notorious for exiting out things that I won't sign and calling up and saying, so what's the symptom that we're treating here? What are you expecting to happen? Okay, there is one medication for that. Or I might choose something that could do that. But I said, I'm not giving you all four.

But I wonder, Patrick, you bring up a big point being from Massachusetts where there was the whole tragedy of compounding pharmacists with a whole steroid point and people died. I mean compounding for pharmacists were not under even the DEA, there was no oversight for them. And so there's a financial part for compounding and there wasn't any oversight. And I wonder if some of this compounding will change what we were doing because there will have to be more data to it. And I think it was all done with good intentions of like, we don't know what to do and so let's just try and treat it. But I think we're 30 and 40 years out and it's time for us to really think about the science.

Patrick Coyne:

No, I would agree. I think I published something back in the early 2000s about compounding, another place that got booted off the [inaudible 00:39:14]. And I think it was because I was having such a hard time with some compounding pharmacists. We had one in town that was making 29 milligram, long-acting morphine tablets every 12 hours, and charging \$4 a pill because 30 milligrams was too much for the patient. And I was just like, this is highway robbery what's being done. Or a bone cream that the ingredients were secret. Why would I order it? So those are the kinds of stuff that would drive me insane.

Dr. Lynn McPherson:

But closed provider pharmacies that provide medications for hospices still have an extremely robust formulary of combinations of Ativan, Benadryl, Haldol, and Reglan for topical administration. My other enormous pet peeve is I remember for years I did the top of Cat Walker on speed dating with a hospice pharmacist at the Academy Annual Assembly Meeting, and the first time we did it I sent an email to a large hospice that I've worked with. And I said, anybody have any good medication tips? And I swear to you, 8 million nurses emailed me back and said, do you know you can take any tablet or capsule and insert it rectally and it will get completely absorbed? I'm like, that's not true, that's not true. And my

favorite is phenytoin where the advocate for poking a pinhole in the end, I don't know if that's for dramatic value or what, but the patient will be dead five years and it'll still be there in the rectal hole. I don't understand this, I don't understand it.

Patrick Coyne:

There are so many old wives tales that exist, and I think you just have to keep moving and trying to get them through. But to this day, I'm still hearing them when I'm on the phone saying, well we're just going to give that sublingually and I'm going, I don't think it's going to absorb quick enough if you're saying they're screaming right now. So why don't you put a subq needle? I mean it's just like, well we don't want to do that. I'm just like [crosstalk 00:41:11].

Dr. Lynn McPherson:

But I do think we need to be careful to recognize that there are many compounds that are efficacious. I think the big thing is knowing when you got good data, like for example when a pharmacist can make a high concentrate, intense al morphine of 30 or 40 milligrams per mil, that's a godsend, or methadone. I do like intensols, Patrick, particularly in a situation where it doesn't need to get rapidly absorbed, it's just a matter of the patient's unconscious. Using an intensol, propping their upper body up 30 degrees and putting up to [inaudible 00:41:41] cavity. Really it gets GI absorption anyway, but it's a beautiful thing.

Patrick Coyne:

To the back of the throat, and that's what I-

Dr. Lynn McPherson:

Exactly.

Connie Dahlin:

And I think what you're talking about, Patrick, also is this part about as expert clinicians and leaders, how do we help just in time learning to say, it is fine to use that but let's just talk about the situation and what's going to happen. Right drug, but what's most effective? And I think, Lynn, to your point of, I even think in the hospital when we're ending up using a lot of a high dose morphine and you go from a ten to one to a 50 to one. Okay, that's great and we need it, but then we have to teach people about what that means with the pump and what they can do with a breakthrough dosing. Because sometimes people don't understand that once you get up that high, then it's also going to affect your breakthrough dose.

And in certain sense okay, that's great because it has to be a percentage, but I'm always intrigued when we have people at, let's say 50 to 75 milligrams an hour of morphine, and they want to give a one milligram morphine bolus. Okay, let's talk about cooking, right? When you increase the amount of the recipe you have to increase the dose. And really trying to help people understand those principles. But, I mean I think in all of this you've talked about leadership of the team, leadership in pharmacy, leadership in research. When you think about where we are and where we're going, what do you worried about?

Patrick Coyne:

Sustainability. I worry a lot about that from a clinician point of view because I don't think there's enough of us and the populations getting older. And I'm seeing a lot of people that I kind of grew up with

retiring, so that worries me. And I don't see many fellowships and I don't see many training opportunities for others, nurses, and social workers, and pharmacists, which I think need to occur. So those things do bother me. I see hospitals trying to figure out how to do palliative care on the cheap, like let's just put an NP in there and we'll say we have palliative care, and there is no psychosocial support. And that kind of bothers me a lot too saying yeah, we offer it because the hospital eight miles down does so we're going to say we do it.

And if you're putting an NP or a DOC in place and calling it palliative care, it's palliative medicine because really you're just doing pain and symptoms. And let's just say what it is, because there's no way I'm a chaplain. There's no way I'm giving spiritual support. And I don't know the psychosocial, I don't have time to meet with the family and do bereavement support or grief support. It's just, there's just not enough of it, and if you're a one person show you can't do that. And so that bothers me because I think we, a good program is strong and I don't want the nationally palliative care to get weaker because people are building weak programs.

Connie Dahlin:

So as you're kind of thinking about just where we are, I mean do you feel positive that we've made enough strides in the last 25, 30 years? And that if we continue at this rate we'll continue to grow?

Patrick Coyne:

I mean I'm optimistic. Let's be honest, it wasn't here back then, so look at what's evolved. And that's good, but how do you keep that momentum going? And I think that's sad, so I think the PhD program and master's program in Maryland's a good example. I think if you look at programs, there are other programs around the country that are trying to do this stuff. And I think there's a lot more educational resources that were not there. I think those are all valuable, but you got to keep the momentum going.

And I think we have such a little voice when you look at the dedicated research at NIH and NCI, how many fellowships are supported through institutions? Given I came from an institution where we supported a fellowship with golf tournaments and praying that people would donate, you can't survive on those kinds of things because you don't hear that with other fellowships. And it has to be interdisciplinary. And how do you support training for chaplains, and social workers, and pharmacists, and the nurses there? Because you need the whole team, and I think that's hard for administrations to understand because there's not another team sport in medicine.

Dr. Lynn McPherson:

We're transdisciplinary, baby. Don't forget that in our master's and PhD. That's [inaudible 00:46:50] all the way.

Patrick Coyne:

I get that, but we don't fit into the medicine model well. And I think with hospitals going to ACO models, palliative care becomes critical. And so the more and more hospitals that embrace the ACM, the accountable care organization model where you're responsible for this population. If you don't get palliative care in that mix you're not going to do well. But I'm finding a lot are bringing in late, or an afterthought, or thinking one discipline is going to make it work. And it's not fair to whoever they bring in, it's not fair to the patients and families.

Connie Dahlin:

Well Patrick, you have made us think about a whole range of things. And I think for our students to understand that there's many possibilities for them to step into leadership, from policy that you helped with the state of getting educational requirements, to thinking about even small research, whether you can get it funded or not, sometimes it's still important to do it for the field. Thinking about the clinical expertise, thinking about education, local and educational wise. And then also just thinking about strategically working within a hospital administration of kind of showing your value. So thanks for everything that you've done, thank you for having a really interesting discussion today. And we're very grateful for all that you've done.

Dr. Lynn McPherson:

Thank you, Pat. Thank you.

Patrick Coyne:

You guys take care.

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 presentation is copyright 2021 University of Maryland. For more information on our completely online Master of Science, PhD, and Graduate certificate program in palliative care, or for permission requests regarding this podcast, please visit graduate.UMaryland.edu/palliative. Thank you.