Transcript / A Strategic Path Forward for Hospice and Palliative Care with Dr. Ira Byock

[00:00:00] **Melody King:** Welcome to TCNtalks. The goal of our podcast is to provide concise and relevant information for busy hospice and palliative care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host, Chris Comeaux.

[00:00:23] **Chris Comeaux:** Hello and welcome to TCN Talks. I am very excited today.

We are really honored to have Dr. Ira Byock with us. Dr. Byock, welcome.

[00:00:32] **Dr. Ira Byock:** Thank you very much. Thanks for having me back.

[00:00:35] **Chris Comeaux:** Oh, it was good to have you back. Thanks for actually poking us. And actually, I would've probably reached out to you if you hadn't. Um, I want to first just read for your bio. I imagine every listener knows who you are, but, um, just in case, Dr.

Ira Byock is the leading palliative care physician and author and a public advocate for improving end of life care. He's the founder of the Institute for Human Caring of Providence Health. He is the past president of the American Academy of Hospice and Palliative Medicine from [00:01:00] 1996 to 2006. Dr. Byock directed Promoting Excellence, end of Life Care, a national grant project of the Robert Wood Johnson Foundation.

He's also emeritus Professor of Medicine and Community of Family Medicine at Dartmouth. Um, is it Geel, Geisel, Geisel, Geisel, of course, school of Medicine. He's authored numerous articles in academic journals and opinion essays, national newspapers, online health news sites, his books, some of my favorites, dying Well for Things that Matter Most, the best care possible.

So, truly honored to have you here. Welcome Dr. Byock. Is there anything I left out that you would want our audience just to know about you? Uh.

[00:01:39] **Dr. Ira Byock:** Father, husband, grandfather, uh, fly fisherman.

[00:01:47] **Chris Comeaux:** Oh, that's cool. I did not know that about you. That's actually really cool. Well, if you're ever in Western North Carolina, you need to give me a call in 'cause there's some great fly fishing in this area.

Uh, I'd love it. Awesome. Well, [00:02:00] um, I and you always, you, you, you chastises me in a good way to always call you Ara. But I wanna start off as Dr. Ira Byock very, um, out of respect for you because this paper, so you just recently published your Strategic Path Forward for Hospice and Palliative Care, a white paper on the potential future of the field.

And first off, if I could jump up, I know some of our listeners just listened, but if I could jump on the table. And give you a standing ovation. That is how poignant this is. And, um, I was sharing with you as many leaders, I consume so much information, so sometimes you're speed-reading things, but I knew I had to come back and marinate in this, and I did that this morning.

I'd literally just outta respect from you, Dr. Ira Byock, because this is incredible. And I wanted to ask you and, and, uh, I prepped you that would say it in this way, but is this a magnum opus of sorts or, or is it a natural stand at the right time? Or is this kind [00:03:00] of a bit of both?

[00:03:02] **Dr. Ira Byock:** I think it's hopefully a bit of both.

It's been living within me for a very long time. Chris, uh, this, the NIUs of this, uh, White Paper, uh, started back, I don't know, three or four years, at least three years ago, uh, I have been, um, losing sleep, frankly, literally over the, the state of this field that I love so very much. Uh, both particularly hospice care, which we'll probably spend most time talking about, but also, um, palliative care.

And, and it's been, it's been, uh, a source of real consternation for me, not only professionally but personally, and I've been chewing on it and reading as much as I can and trying to figure out how to make change and where we can, how we might, um, reinvigorate this field with, uh, the bright future that we had always foreseen.

Those of us were around in the late seventies and during the eighties. [00:04:00] Uh, and so, um, I worked on this for many, many months and, uh, it is, for me, it, it is a professional contribution and, and, you know, I'm late in my career. Uh, one of the most important things that I've done in the last several years, but it's also, frankly, a, a bit of self-care.

'cause if I didn't get this out, if I didn't express. What I saw and the, the real potential to reclaim this field, uh, for those of us who practice within it. But ultimately, and far more importantly, for the patients and families we serve, I was going to have personal dis disease. So I have to say, uh, getting it out,

expressing it, uh, kind of validated, um, the many, many months that I, that this was, uh, a work in progress on my desk.

[00:04:54] **Chris Comeaux:** Wow. Well, there's a couple things you said in the Green room that I think I want our listeners to benefit from. When I told you I was gonna ask you [00:05:00] that question about, is this your magnum opus? Um, can you share what you shared about your, your, the best book, the best care possible? That book? Well, sure.

[00:05:07] **Dr. Ira Byock:** So, the best care possible really, you know, I would probably tell, uh, um, you know, my biographers that, that, that was my magnum opus.

That was, that was, uh, uh, work of head and heart, uh, a three-year project. Uh, I wrote that book while I was actively practicing and managing a very busy palliative care service at Dartmouth-Hitchcock Medical Center in, in New Hampshire. Um, and, and it, it was again, a way of expressing what I saw as, uh. The bright potential of the field, uh, helping, um, the general public understand what palliative care really is through the aegis of stories of real people that I was privileged to help care for and our team was privileged to help care for, but it was also directed at, uh, [00:06:00] young clinicians, uh, who, uh, are clinicians in training, uh, and, and those early in their practice to kind of, um, make the practice of palliative care and.

Um, and the way we approach, uh, the best care possible, which is what we all want for ourselves and those we love, and the patients who we serve, to make it tangible because I think it's so abstract often when we, when we talk about it. So, it's a story driven book. Um, many of those stories are very dear to me.

There's, there's some very personal stories, including of my, my dear cousin Edith is in that book. Um, and, uh, yeah, that would be what I would identify as my magnum opus. Um,

[00:06:45] **Chris Comeaux:** well, and here's why. Here's why I wanted to ask you that question and thank you for sharing it in that way. Um, our, our mutual friend Cordt Kassner, um, and the top news stories of the month, we gave this a shout out.

I told him we're gonna be doing this podcast. And Cordt said something [00:07:00] that quite frankly at the moment, I'm like, huh. He said, you know, I hope this article was used in the boardroom with hospices all over America,

nonprofit for-profit, whatever, um, to provoke discussion and really deep thought. And I'm like, that's an interesting thought.

After marinating in this this morning. I think that's actually brilliant. And, and you said to me in the green room, I put my heart in this. Can you share just a little bit more about, you even talked about a ritual before you would write on this.

[00:07:26] **Dr. Ira Byock:** You bet. You bet. Well, so I know that what I've said in this paper, uh, while I think it's a quite constructive, is also provocative and it's intentionally provocative in a, in a, in a good way.

Um, I knew it was gonna generate discussion. I intended it to generate discussion. My personal discipline in sitting down to write every day that I spent writing was to center myself in loving intention. Uh, take some deep breaths, just quiet myself, close my eyes for [00:08:00] a few moments, and really sink down into, uh, IRA, write this from love.

And that allowed me to say some difficult things. Uh, and as you read, you know, there are some difficult things that we have to confront in our field. Yep. But to, to say it with the love that I feel for my colleagues, for this bright, beautiful, uh, specialty that we all created and, uh, and for the patients and families we serve.

[00:08:28] **Jeff Haffner / Dragonfly Health Ad:** Thank you to our TCNtalks sponsor, Dragonfly Health. Dragonfly Health is also the title sponsor for leadership immersion courses. Dragonfly Health is a leading care at home data technology and service platform. With a 20 year history, Dragonfly Health uses advanced technology and robust analytics to manage durable medical equipment and pharmaceutical services as part of a single efficient solution for [00:09:00] caregivers, patients, and their families. The company serves millions of patients annually across all 50 states. Thank you, Dragonfly Health for all the great work that you do.

[00:09:14] **Chris Comeaux:** Well, I know we want to get into the meat of this, but maybe one final commentary about it. Um, you know, we live in the time artificial intelligence every day it's getting more and more fascinating.

Uh, executive producer and I were talking this morning about a mutual podcast. We both saw, um, A-G-I-A-S-I and where all this is going and just the heady left brain stuff of that. I am a huge admirer when someone weaves head and heart throughout a paper. And so you've got data and you've got head and heart.

And so just, I, I'm an admirer when I see that, that jumped off the page. I mean, there's some phraseology in here. I'm like, oh, I'm adapting that. That's awesome. And so just again, kudos to you. I think you, you struck that chord, which this is a very heart-centered [00:10:00] work and it started off that way and it's kind of interesting.

I could look through my career. I'm a CPA 25 years old. I'm, uh, at a hospice in Pensacola coming from the business world. And I'm like, what have I just fallen into? I came from the business world, so I was of kind of that different generation as opposed to the matriarchs. Patriarchs like yourself that created this thing.

And then you saw the swing to the business left brain data side. And you know, maybe the, the future is, can we bring those things together? And in some respects, I feel like you did that in this paper, so it's one of compli. We can do that.

[00:10:34] **Dr. Ira Byock:** I mean, yeah, I was part of founding this field and it has a lot of science and physiology and pharmacology and all of that, but there's also heart.

We were, we were never supposed to be just another specialty. But you know, the fact is I'm also a capitalist. I, I really believe in capitalism. I, I think it's not perfect, but it's, uh, it's the best system that I know of. [00:11:00] And, uh, and I, and we'll probably talk about this, but sometimes people have criticized me for saying, well, it's all sounds like you're, you know, not very, you know, you're, you're, uh, down on capitalism.

Well, I'm down on greed, but I'm very much up on capitalism and I, I think part of what. I think the strategy does, it takes the energy of capitalism and helps it to drive change in a way that, um, advantages, quality and, and, and the services that we provide.

[00:11:33] **Chris Comeaux:** That's well said. You know, one of my favorite podcasts, I think it was.

Uh, I can't remember which one it was, but the guy was Jeff Sandifer. He would write, uh, cases for University of Texas. I think he was at HBR first and then he went to University of Texas. But he ended up, uh, creating like a Montessori school based upon cases. But he said something I had never heard before.

He said The brilliance of the American capitalist system is it's a canvas for multiple games to be played out [00:12:00] simultaneously. And if it's done well, it creates win-win all the way around. That's right Now if the game gets rigged and other, and all of that negative stuff. But I thought that is actually brilliant.

And I, and I think you're calling that out in this as like competition's a good thing. Um, cronyism is not a good thing. Or just greed or just, you know, doing this for the financial aspects. That's where you go wrong in any system actually. Um, I had a lady on my podcast who wrote a book called Ethically Challenged, and she was really poking on private equity.

And I was listening to all this research he did and, and like my final thought was, I don't care what business you're in, if you're not about better service, better quality, and the most value you shouldn't be in business. And I think in some respects, that's our own medicine within this, this field of hospice and palliative care.

I couldn't agree with you more. Well, well, let's jump in then. So, I think we've, we're good. We kind of frame the, the field, if you will, but the very beginning is you're, you're laying out the problem and, and do you want to take it from [00:13:00] there? What is, what's our problem and why is the problem now that we have to confront it?

[00:13:04] **Dr. Ira Byock:** Well, so we've had multiple huge successes in our field. I mean, look at the growth in, in hospice. You know, I remember when hospice was 10 demonstration projects with Medicare funding. Hospice has grown dramatically. Um, and, and that's a good thing. And we're caring for, uh, half or so of, of people who die on Medicare.

And we could go on and on. But, um, but as we've scaled up, and oh, and palliative care, along with hospice care has become a formal subspecialty and caps. C'S data shows that palliative care is available in 80% of hospitals with beds more than 50, uh, beds. Um. Academically, the field is thriving. Um, you go to the, you read the journals and go to the, uh, conferences and, and it's totally exhilarating.

It's really, there's, there's much health and vibrance in this field, [00:14:00] but we have growing pains and as we have grown. Mm-hmm. And this is particularly poignant in the hospice side of the field. As we have grown, because of the Medicare per diem, there has been opportunities for, uh, extensive profit taking in, in the field.

And as you know, as, um, the field has grown and, uh, we all saw back in the day, I knew of quite a few. Uh, privately owned, usually family owned hospice companies that were providing phenomenal care. These were people dedicated to hospice. Uh, the, again, the family was usually, uh, involved in, in their business.

I watched them, uh, go all out to provide the best care for, uh, patients. They reinvested their money in, in staffing, expanding staffing, expanding services, then expanding programs so that they could care for more people. [00:15:00] And I, I, frankly, was quite enamored, uh, having already as a young man sat on multiple nonprofit boards and found, having found, founded several, uh, even early in my career, nonprofit organizations.

Uh, I was enamored with the for-profit model. It's very efficient. You can move capital and do investments and, and, and development easily. So I thought this was a winner. What happened was that the for-profit, uh, segment of the for-profit companies went through IPOs. They went through initial public offerings mm-hmm.

And became shareholder, uh, owned. And despite the attestations, that quality wouldn't change. Within two years of making that change, I saw, uh, several, uh, companies who had been utterly committed to excellence, start to diminish in, uh, consistency, reliability, uh, and quality. I [00:16:00] saw staff, um. A stress increase, a cuts made in staffing and the like.

And when you think about it, this isn't immoral, but when you go through that process and you have investors who have put their good money into your company, then uh, the um, commitment is divided. You're not just committed to providing the best clinical care and services. You also have a legitimate important commitment to your shareholders to give them a reasonable return on their investment.

And what we have seen with the corporatization of American healthcare in general is that some segment and quite a significant segment of the investor owned healthcare companies are really, uh, advantaging their investors more than. The staff that they employ and the patients and [00:17:00] families they serve. So I think capitalism is a great system, but it has to happen within the con context of a commons.

Right? You, you, that's basically what you just said. We, we have to also do business with an understanding that we, we live in a society and, and communities in which the welfare of the community is, has to be built into our

strategic business plans and, and growth plans. And frankly, that that hasn't happened.

So you have over, over the last. You know, decade we've seen, uh, more and more. First it's anecdotes of, I get the occasional, uh, uh, letter from a, uh, aggrieved, uh, adult child of somebody who died saying their hospice experience was really difficult, really problematic, they felt abandoned, et cetera, et cetera.

And then we started seeing, uh, OIG reports from, you [00:18:00] know, the government's OIG reports saying there's a number of hospice programs with serious deficiencies. Uh, and while, uh, the National Hospice and Palliative Care Organization or others would sort of say, oh, they just don't, their, their methodology is wrong or whatever, those were pretty consistent.

And now, you know, then, then the journalists got involved and we saw Time Magazine and Kaiser Health and mm-hmm. Uh, uh, political health and, and then, you know, uh, the New Yorker and ProPublica, and now John Oliver doing exposes. About hospice care that was really dangerous and, and bordered on abandonment or frankly was frank abandonment.

So we have a problem. Um, and, and I think, um, this field, which I dearly love, has been skirting the problem. It feels [00:19:00] disloyal in some circles to even bring it up. But in order to get to solutions, we have to get past denial and begin to realize that some segment of this field that we love is ill and needs strong medicine.

[00:19:17] **Chris Comeaux:** Talk about the disloyal for a second. 'cause I sense that as well. It's like, um, I, I realize there's a couple things you say in here, like at the very beginning when patients were in such situations, they meet hospice and palliative care teams. It's as if there's a break in a dark storm. That is a brilliant phraseology that, it's interesting.

I've always kind of envisioned a commercial like that. Like there is this like promise of the third act in retirement and then the serious or advanced illness comes upon 'em and it's like a storm. And, and so there is, there's a sacredness to this work. We walk on holy ground and so to speak about it. Can you just talk about that just for a second?

'cause I get that [00:20:00] hesitation, but once you've put this on paper, it's like the time is now for what you just did.

[00:20:04] **Dr. Ira Byock:** ~~Did.~~ Right? We, we've invented a model or developed a model that works brilliantly. It's darn near magical. When it works well. A well staffed, highly functioning. Hospice and also palliative care program is really remarkable in its power to turn things around for a family, not, not that we're going to change the force majeure, we are all still mortal, right?

But in, in a, being able to give them not only comfort in the moment, allowing them to feel heard and understood. But also to develop confidence that we are now being cared for by people who get us, who understand our needs are, are not just meeting our needs, but anticipating our needs. And it's like, you know, when I, uh, was a medical director for a hospice program, which I was for many [00:21:00] years, I used to say we ought to be like the, the big warm glove, like a catcher's glove.

Like you can't have a problem that we can't respond to sufficiently, right. We, through our planning and our protocols and all the work that we do to constantly prepare, we've got you right. Whatever happens, we've got you. I find that that's still real. Chris, but it takes, um, a, a true interdisciplinary team, not a multidisciplinary team, a true interdisciplinary team, a team that conferences together, because I think some of that magic happens in the interdisciplinary team planning meeting where that's where this, the whole becomes more than the sum of its parts, you know? Right.

[00:21:54] **Chris Comeaux:** That's brilliant.

[00:21:54] **Dr. Ira Byock:** You say, uh, and it takes a team that has worked together and drills together [00:22:00] and, and anticipates what could go bump in the night for this patient and family. Right. One of the things that I've done with every clinical team I've managed is the charts. Our charts always have a specific crisis prevention and crisis intervention section.

What happens, right? If, if all of a sudden somebody, the the patient, I don't wanna get too gruesome, but you know, has crescendo pain, they, they have a bowel infarct or, or my god, start bleeding profusely or have terminal delirium and, you know, or, or, or end up with status epileptic is where they're seizing.

W what happens? Do we have a, do we have a response to that? Do they have the medications in the home that they're gonna need? Is, you know, do we have somebody on call? Is there a pharmacy open? And if not, we better make sure we have vials of whatever they're gonna need so that they get the same dose of medicines in the home that they would get in an [00:23:00] ambulance or the er.

All of that stuff is very detailed, very left brainy, but that's the stuff that makes what we do s so magical and it's part of what I see being drained away as caseloads increase. Physicians are, you know, the, the three S's, you know, show up, sit down and sign. Right. Um, the, the responses to emergencies are, are tenuous at best.

All of that, uh, I see draining away. And that's, that's the magic that, um, we can no longer bring in in places. Though I should pause and say many hospices are still doing it and doing it well, but a troubling proportion of hospice programs now are, are walking through it and they may fill those, um, positions, but there's not [00:24:00] that magical synergy, um, that I've, I mm-hmm know is part of what makes us so powerful.

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[00:24:09] **Chris Comeaux:** couple comments just listening to, um, university of Virginia, Darden School of Business actually did a case study on the work that TCN is doing, and it, it kind of bothered me at first. Um, but they started the case study 'cause it's like we're trying to work with nonprofits to give them a pathway to the future.

And, but some of the things they highlighted in this case study you were poking on, but they started with an Eric Fer quote, and it just haunts me. It says Every great cause began in a movement, began as a movement, becomes a business, and eventually degenerates into a racket. Now that's very poignant and very maybe overstated, right?

I do not believe the hospice field has become a racket, but unfortunately there is a segment and there's some icky things that you call it out in your, in your white paper. I mean, if you look at states like California, Nevada. There's some stuff that's [00:25:00] just not even in the realm of what you just described as, um, I, I like basketball.

I dunno if you know, like basketball, love Steph Curry. Um, I heard a podcast where he talked about the sixth man on the basketball court is the ball. Most people go, what the hell is he talking about? You're talking about that magic. Like there's something about when that team functions together, it's magical.

You know, one of

[00:25:22] **Dr. Ira Byock:** my own metaphors for this is a basketball metaphor, and I didn't, I didn't create it. Uh, we were having a, a team development

meeting. This is back, gosh, 25, 30 years ago. And I was the medical director of a hospice program in Missoula, Montana. Right. And, and we were having this development, uh, meeting and, and, uh.

And I asked, so what, what does success look like for us? You know, what, what, what does it feel like or look like when things are going well? And, uh, this, uh, nurse, his name was Mark White, uh, said, I know he said, it's like when you're playing basketball, [00:26:00] it, you're running down court and, uh, the guy with a ball, uh, uh, bounces a pass to another player.

He's not even looking at, he's looking one way, bounces the pass, and the guy is there because, you know, he's gonna be there to pick up the ball when we're working. Well, it's as if we're working, we're like one entity with, uh, a number of, of players, but we've got it. And, and again, I went back to, you know, you can't have the patients and families can't have a need that we don't have an early response to.

[00:26:32] **Chris Comeaux:** And you think about that level of like, you know, getting Steph Curry, golden State Warriors, watching that level of basketball, which is, you know, the hospice I would want to be a part of would be. Having a Aya and our team, I had a Janet Bull on my team. I was blessed. We were doing amazing things. And then recently I, I played, I'm, I'm in my fifties now and so I hadn't shot in a while and my daughter's dating this young man.

And so we played, and I wouldn't call what I was doing playing basketball, but unfortunately throughout the [00:27:00] country, all of that sometimes is passed off as hospice. And there is, there is that variability. So maybe where we need to go now is like, well, what's the solution to this? 'cause I think you start to lay out a pretty amazing framework that made me think, and that's my guess is you weren't trying to write the whole prescription, you were trying to put a framework to push this conversation forwardly.

Am I reading that right? And,

[00:27:21] **Dr. Ira Byock:** and, um, I hope we get to talk about what the resistance to this plan is because, uh, um. Because I think it's doable. Uh, first, first before we get to a, the four components of the strategic plan, uh, the first element is we have to formally adopt a stance of zero tolerance to fraud and abuse in our field, right?

The boundaries of collegiality need to stop at criminality or patient harm. Uh, we are the, we are the people who [00:28:00] know who else, what other

companies in our community are disserving, seriously ill patients and their families, the most vulnerable patients in our healthcare system. So that's number one. And we can work with government, but we ought to step up as a, as a field and as an industry to, if we need to set up hotlines for anonymous.

Tips work with the government to say, Hey, check, take a look at this. We think that there is unsavory business practices here and, and lean in because if we don't do it, the patients and families are, are really at risk. And today they are really at risk. And you said it mostly in, you know, the Southern California, Nevada, I, I throw in, uh, Arizona, some areas in Texas, Arizona, but it's scattered across the country.

The Yep. The southern states also that are having real problems. So it's, it's around there. Um, so then [00:29:00] the, the components of this strategic plan are quite simple, frankly. It is clear, explicit standards for both clinical care and programmatic standards for the structures, the processes of care, and. Um, and including staffing for what makes a program real.

There are hospice programs today and, oh, by the way, palliative care programs today, that if you were to do a site visit or spend time with them, you would conclude they are hospices in name only or palliative care programs in name only. They don't, they just don't have the resources and the data shows it so clear clinical and programmatic standards.

For years, many of us have been urging the national associations to finally publish standards working from the conditions of participation in palliative care, working from the, um, [00:30:00] consensus document standards, but make them operationally explicit and where the, where it's necessary. Use numbers for staffing or caseload ratios and, and those sorts of things.

Second, uh, element is develop metrics and there are many metrics out there, but come to some general, something close to a consensus about quality metrics that build on those explicit standards and allow us to look at which programs are staffed well enough and whose processes are, um, practicing consistent with this standards that we have now finally elaborated.

We need to make those as good as we can. Though they don't have to be perfect, they should always be seen as iterative. They can [00:31:00] change yearly or every few years as the technology and the methodologies and the data sources change. Or improved. They need to be meaningful and they need to be public facing.

Right. I, you know, I frankly think star ratings are X are great. They need a lot of improvement. They need to be seen as iterative and always as kind of a work in progress with, you know, uh, uh, a year tied to them. So we know what version of the star ratings we're talking about, but they are the sort of things Yep.

That, um, doctors who refer patients to hospice need to look at. I would say the same thing about palliative care, but we're mostly wanna focus on hospice. Um, discharge planners, uh, need to look at and patients and families as they are looking at this important decision of enrolling someone they love in a hospice program.[00:32:00]

What do we need to look at are, you know, um. I, I, I'll just go further. We can come back to that. Um, third, uh, is we need to drive competition toward quality competition in a, in this capitalized and capitalistic, uh, healthcare system can be a good thing, but it should be, um, tied to quality. And I think we, although many people feel disempowered in our field, I think we still have sufficient leverage to publish those standards, create those quality metrics, and then push them.

To the, the referring community, to the general public, all of whom may be our patients to the [00:33:00] payers and say, this is what we believe is essential. So we wanna, you know, create, if you're old enough, you remember the good housekeeping seals of approval. We've needed them for years, but we really need them now.

And if you think, if we could come to some agreement about metrics that separate, not just the, uh, bad from the good, but also the excellent from the mediocre, we can continue to drive competition and business toward the excellent, which, which floats all the boats. Mm-hmm. Right. And let the, let the competition be fierce.

But let's absolutely ground it in measurable quality that matters to the patients and families. And then fourth, this field finally needs to address the issue of what is our authentic brand. [00:34:00] We have skirted this for years, and I, I say it in the paper, but it's so poignant for me to see or, and to hear colleagues who are afraid to introduce themselves to patients.

As you know, we're from, um, uh, uh, Acme, uh, hospice program because they don't want hospice on their name tag because they're afraid of, you know, freaking out a patient or family. Uh, I've had an oncologist, literally, this is a real story. Tell me, IRA, I love your palliative care program. My God, I don't

remember how we used to take care of these patients, uh, before you guys built this program.

But could you just call yourself something else? Because I, uh, my sense is that pal, when I say I want somebody, uh, I wanna refer you a patient to palliative care. I'm afraid of scaring them, which was ironic because, and I pointed this out to 'em because we're having this conversation within a cancer center.

Right? You wanna know that a word that scares the, the [00:35:00] Jesus out of people just tell 'em they have cancer, right? Is the word cancer? So, you know, we can change the name, but maybe we should also change the meaning of what it means to be referred to a hospice and palliative care program. And as you've read in the paper, and I hope our listeners do take the time to read this white paper.

I am quite clear I have been for quite a while that our authentic brand is expert care for patients that drives toward fostering wellbeing during this inherently difficult time of illness and caregiving and often dying and grieving that human wellbeing I know is still possible even in the midst of illness.

You know, I've written several books of real stories of people who express a sense of [00:36:00] wellbeing, but you can also find it in biographies and, and, you know, memoirs that illness as hard and as unwanted as it is sometimes is also consistent with people, uh, feeling well within themselves. Right with the world, right.

With the people they love. Right. With nature or their God. And the distinguishing feature of our field is not that we manage symptoms well, or we know our opioid rotations. No, we do that. It's not just that we pause and listen and make sure that what we're doing is consistent with what people, what matters most.

We do that, but so does a good family practitioner or oncologist or internist. What distinguishes our field is that we do all of that and then we listen and try to discern what would be left undone in this patient or [00:37:00] family's life, what's left to celebrate? What would give them some joy? I don't know of another specialty that does that We it, it's often not talked about because it's so embedded within the culture.

Of our discipline that we don't even recognize it, but it is a distinguishing feature. Yeah.

[00:37:23] **Chris Comeaux:** ~~I'll,~~ I'll just comment to that and then I want to back up on each of these 'cause it is such a great framework. Um, I read, read a, a book about how to think like Socrates recently, it's, it's a fascinating read. It's, I love history.

So it's kind of a history of Socrates. It was teaching you how to think like Socrates, but I did not know that Socrates at the time was working on this concept of the good life. It was a, a, a Latin term. I think it's, it, I can't even pronounce it. It starts with a e and like, what is the, the weight of a good life?

And it's fascinating. And in kinda some respects, he got put to death because Athens said he was trying to [00:38:00] corrupt the youth of Athens because he was wrestling with those core question. And to me it reconnected me with why I just fell in love with this work that we do. And. I came up from the finance side of the house was paradoxical.

That's more the left brain, the data side. But very quickly, I was raised by some amazing nurses and I just fell in love with this. This is unlike anything I'd ever seen in my life and this concept of. W the, the weight of a life. And it's, I I don't know if I ever told you this, Dr. Byock, um, when I first came in as A-C-E-O-I was young, I was 30 years old.

And that adage of nurses eat, they're young and I felt like I've got no cred with these nurses. So I start working my master's of gerontology and it was a fascinating time to be in gerontology. 'cause you had the anti-aging pill and healthy aging, so you saw two converging Rivers. Well, long story short, I wrote a paper about, uh, and I, the title of the paper is what did Viktor Frankl and Curly from City Slickers have in Common?

And if you remember that movie where Curly said, [00:39:00] you gotta figure out the one thing. And I basically said this in the paper, if you tell people they're gonna live forever via a pill, you remove all necessity that you're a finite human being and cause and purpose will go away. That's kind of the gist of the paper.

And, and you know, now I could look back on that and kind of maybe my youthful exuberance. Yeah. I actually understand that in a much deeper level that that. What we call the good death when, when, and doesn't happen every time. But when you see those, those reconciliations and words said that people hungered their whole lives.

And we created the canvas for that as hospice and palliated care. That's an amazing thing. Um, I once had, a woman came up to us at a fundraising event

and it scared me 'cause she pointed her finger and she said, you need to understand what y'all do. And I thought, oh God, this is a service recovery in a, a black tie affair.

But what she told me was this beautiful story of our c continual continuum of care. And before her mom died, she spoke a blessing over her and she said, I [00:40:00] literally heard words I wanted to hear my whole life. And this was the punchline. This will change the trajectory of the rest of my life. ~~That is why I~~

[00:40:07] **Dr. Ira Byock:** That is why I do this work.

Right? I, I thought I was going to do other clinical work, but what I realized early on in, frankly in my training was that there was this. Human potential for wellbeing in the midst of this, the tragedy of, of, uh, life limiting illness, and I don't use the term good death. I, I, I talk about people dying. Well, right.

And I, that phrase mm-hmm. Is not just, um, well, is not just a, uh, adverb describing the process of dying. It's an adjective describing the person who is dying, that they are well within themselves. Right. You can die. Well, human wellbeing, I'm [00:41:00] a, I'm a human developmentalist. Right. I, I am back, I was a family doc for a while and I was trained as a family doc.

I, I was steeped in Maslow and Erickson and, uh, PI and mm-hmm. And, uh, all this, you know, family systems, theories, and, and. And all of them, all of the developmentalists say that human development is a lifelong process. And while they all focus on, you know, neonatal and early childhood development, adolescent development, um, I think what we have done in our field is to show that indeed human development is a lifelong process.

If you sit and listen to people and learn who they are, not just as a set of problems on a list, but as a whole person, you can get a sense of, of, uh, what opportunities are still with them to, to develop. Fully, [00:42:00] what would be left undone or what would give them joy or what feels incomplete in their life?

How can we help them honor and celebrate their lives and, and relationships? Once again, this is something that we do naturally within our field. There is no other specialty that does this. This is our distinguishing feature.

[00:42:27] **Chris Comeaux:** And, and maybe I, I've loved the way you just phrased that I'll say has the potential too, right?

Because what led you to this is that there are pockets that are not living up to that. Um, which, and I could just, I feel the weight of what you just said, and then when you get. Certain aspects that unfortunately were period on the John Oliver Show. It just makes you want, I mean, literally, I, I wanted to throw up after seeing that and thought, oh my gosh, that's just, that is so just perverse compared to what you just described.

[00:43:00] Um, and unfortunately we live at a time where sometimes perversity is celebrated more than the beauty of what you just said. But I'm gonna just repeat your four categories, Dr. Bak, but you also kind of, you said the resistance, and that's where I want us to go in the question. But just to repeat, so this broad framework, clinical and programmatic standards, making meaningful data readily available, driving competition based upon quality, and then embracing and promoting our authentic brand.

Why would anybody be resistant to that? What's the resistance maybe that you anticipate it's interest?

[00:43:33] **Dr. Ira Byock:** Um, now this, this paper's been out for a little over a month. Uh, uh, when I last checked, it had. Uh, over 5,400 downloads. So it's being read and being passed around. Um, I haven't heard anybody really, um, disagree strongly with any of the four, um, strategies or components of the, of the strategic path.

I outlined what they say [00:44:00] is, oh, IRA, this is one, a colleague who you would know, um, who's been in the field for very many years, said, oh, IRA, this is painfully ambitious. Um, you know, uh, you know, there's no way that wow, that we can do, we can do all this. I mean, this is a business. We are an industry now.

You're not going to move this industry. And, and I think, um, the resistance that I've heard, and it, it's, it's kind of not loud, in fact, quite quiet. That's the way we resist things in our field professionally. We just politely put our head down and are silent. But the people who have spoken with me express feeling overwhelmed, disempowered, frustrated, helpless, exhausted.

In our clinical work, we've come to recognize those symptoms as the demoralization [00:45:00] syndrome. Right. This is actually kind of a clinical diagnosis. We are, we are disempowered, and I would only say that defeatism is self-fulfilling. Cynicism is self-fulfilling. Mm-hmm. Our field is threatened, but as I've tried to outline, we still have levers to pull.

We can still shape the marketplace of hospice and palliative care in ways that capture the energy of capitalism, enable businesses, whether they're non-profit or for-profit to succeed, having a good viable profit margin, but making sure that the, the, the, the level playing field leveled by good metrics ensures safety and effectiveness of our [00:46:00] services.

We can still do this, so I, I'm begging people to just pause on your sense of defeatism and, and your decision that this is not possible. It is possible. We really can still do this.

[00:46:18] **Chris Comeaux:** Hmm. That is very well said. Again, I think this is why that Kofa quote kind of haunts me, is that if we go with the defeatist mode, every great cause begins as a movement.

That was the patriarchs. The matriarchs, those shoulders that we stand upon, those giants. And I think you're one of those. I know you may not receive that, but you are. But then it becomes a business that may be where we're at, but eventually degenerates into a racket.

[00:46:43] **Dr. Ira Byock:** Well, can I just amplify that? So the, the very similar, um, wisdom from that, I often quote from Max Weber the great, uh, uh, German sociologist and, and economist who said that social movements [00:47:00] that succeed, uh, succeed through the agency of bureau bureaucracies, they become a bureaucracy.

And I have been. Privileged to be part of the social movement that was hospice care and begat palliative care. Uh, and our success generated and was encrusted within both, um, public bureaucracies of, of Medicare and, and, uh, the joint commission and everything else. Mm-hmm. But as well as our own fields, bureaucracies of the national associations and, and, uh, um, the Academy of Hospice and Palliative Medicine, and now NPHI, and then Alliance for Care at home and all of that, our own bureaucracies now, and I think this is a barrier.

We need to look inward and say, have we lost touch? Are we [00:48:00] still first and foremost driving? Quality for the patients and families we serve? Or are we looking at, um, protecting our own, um, you know, um, income streams and our own programs and, and battling the other bureaucracies, uh, uh, saying that, well, the, the, the journalists don't really understand what, what we're doing and they're treating us unfairly, or the OIG is, is using bad methodology and the like.

And I, I think we gotta, we have to get over that.

[00:48:37] **Chris Comeaux:** Hmm. Well, it, it, I feel like you're calling us up and so I, I do get the sense listening to you. This is our crucible. Um, but I think this is our time too. I, I, you know, I was 25 when I came into this, looking up to people like you there a lot of people I talk to, people that I have the privilege of working with, especially people [00:49:00] within our network.

And it is special and it is our time to be part of the solution. Um, the other maybe quote that haunts me is what you permit you promote. And so if we continue to permit these things, um, and what the patriarchs and matriarchs that did that created this movement, um, every generation kind of has its crucible.

So this, I feel like your paper's now calling us into this crucible and maybe it feels a little, maybe hyperbole, but No, it's not. It's like it is at this crucible moment and. I know the conversations in the back room is some of the horrible things, again, depicted by the John Oliver parody. It pisses a lot of people off, but if you just like silently ticked off, that's not doing something about it.

So I think your framework gives people a, a framework. Let's put some meat on the bone, move the ball down the field within this strategic framework.

[00:49:54] **Dr. Ira Byock:** Oh, and can I just add one thing and let's stop talking about, uh, the, the evil [00:50:00] for-profit corporations, right? Um, there, there's problems there and, and they're not entirely blameless by any means, but that, that framing of the problem, it's the non-profits boring.

The for profits isn't gonna get us anywhere. Let's get beyond that, right? You know, this, this strategic path forward that I've, uh, elaborated, just puts that aside. And, and, you know, 70% of hospice programs in this country are for-profit. If hospice is going to succeed in this country, the for-profits have to succeed.

We can do that while improving safety, reliability, and quality of care.

[00:50:40] **Chris Comeaux:** That's very well said. And, and quite frankly, I need to kinda do some, um, reconciliation time, kind of some confession time. So I have a lot, obviously I grew up on the nonprofit side, but I actually grew up in for-Profit America corporate, uh, fortune 50 Company, et cetera.

And so a lot of for-profit people do listen to the podcast and [00:51:00] they do get on me a little bit because I am much more pro non-profit in my communication. The brilliance of your paper, and you just said it, right? Statistics cut through some of the emotion. 75% of hospice is in America, are

for profit. A lot of those practices that tick us off are in that realm, but it doesn't mean every nonprofit's, uh, perfect by any stretch of imagination, and the data proves that out as well.

You give a framework that everyone could agree on and isn't, that's what leadership is about, is what's our common ground. So what I'd love is like, okay, so if people are gonna come out, then what were, where would you push back within this framework? What would you push back? Can we agree to this? And if we're all working towards this.

Then that rising tide will raise. Raise all boats. And one more thing you kind of provoked to me, the other reason why I think the crucibles now, the baby boomers have changed every part of our economy as they've aged. We are on the cross of that. I'm trying not to call it the silver tsunami. 'cause we had a great podcast with the [00:52:00] John a Hartford and ageism and the fours Brilliant framing, by the way, which I think gets to your authentic brand.

I learned a ton from that podcast about the brand. So the huge demographic is coming upon the shore, and it is also a crucible of they're not gonna go quietly. They haven't gone quietly in anything else, and they're gonna want high quality what they get. So it feels like there's a lot converging right here.

I imagine. Imagine you want to comment on several of those comments.

[00:52:27] **Dr. Ira Byock:** Well just absolutely. I mean, we all want the best care possible. Right, and that's a good thing. What the best care is varies from one patient to another, because healthcare for serious illness is highly personalized, right? This isn't LASIK surgery, right?

This is highly personalized and, and, and how we use the diagnostics and therapeutics of healthcare requires going through a process of shared decision making, a values clarification and goal alignment, all of that. [00:53:00] But we all want the best care possible. So, the, the consumer zeal that we baby boomers are bringing to this can help drive change not only for the individual patient and family, but collectively can help drive competition based on quality, right?

We simply need to give them clear standards and then give them the metrics so that they can choose. What the best care is for them. And even collectively, if, you know, if, um, some Medicare advantage plan, uh, decides to, um, keep out of a network, uh, a hospice pro provider that is clearly excelling in the mark, in, in, in quality, their customers are going to that Medicare advantage, customers are going to, uh, push back hard, right?

And it might not change in one year, but before long, the, the quality programs will rise to the, uh, uh, [00:54:00] ahead of this, um. Marketplace.

[00:54:02] **Chris Comeaux:** Well, you know, something else occurs me. I've got like my favorite Harvard Business Review articles ever, and this is in my top five most brilliant article I ever read. And you would love the background on this.

And so I came from Fortune 50, uh, corporate America. I'm 25 years old, find myself in this nonprofit hospice Pensacola. These amazing nurses start mentoring me. I'd go out on patient visits and there was this cool little debate between myself and my key nurse mentor, and. Of course, manufacturing is mass standardization.

And she would say, Chris, cause I would try to bring system and process and she'd say, Chris, this is all art. And I knew she was right, but yet I knew what I had learned. And finally this Harvard Business Review article reconciled it for me. And that there is a place for mass standardization, but there's absolutely a place for customization.

And the more that you have systems and processes that support that, you get that art, those mission moments as we call them in hospice. So, here's where I'm [00:55:00] taking this. A lot of the practices that. Create the horrible perception of what hospice has become is shooting for either mass standardization, no true customization with competency backed up behind it.

Like this is making widgets. And so, systems and processes and highly trained professionals working with a beautiful system, you'll get that beautiful customization, individualized patient care and those more moments of art. But I'll give you a a juxtaposition. We interviewed a person who was in a for-profit, private equity backed, and the margins he shared were pretty obscene.

And he said they just called and said, we want 10% more. And he is like, I don't know how I'm gonna do that without already taking something very thin and making it even worse. And so, they will tout efficiency and 'cause it's really like, um, that old, uh, Henry Ford, right? You could have any colored model t as long as it's black.

I get it, I get

[00:55:55] **Dr. Ira Byock:** it entirely. I get what I'm poking on again, I get, you know, this [00:56:00] is, this is, um. Capitalism unconstrained by the any sense

of the commons. Uh, and and another way of approaching this, Chris, is that I use a lot, is it's the difference between, um, relation based, uh, healthcare and transactional healthcare, right?

And what we're seeing, uh, the, the greed in, in some segments of our healthcare industries in general. But our hospice and palliative care is reducing what is really magical, uh, and highly personal to being transactional. And it's all there, but there's no to it, there's no soul to it. Um, so, you know, the, it's so ironic because we've shown not only that better care is possible and affordable for.

Patients and families, [00:57:00] we've shown that much, much better. Care is both feasible and affordable and, and we can do that and succeed, but there has to be some limit on greed.

[00:57:13] **Chris Comeaux:** Well, Dr. Byock, I want to give you, or I want to give you the last word, but maybe also how would you hope people use this? If you could weave that into your last word, like, I love court's suggestion, Hey, you should be thinking about bringing this into the boardroom, but also leadership meetings, leadership retreats.

What ideas do you have and final thoughts?

[00:57:31] **Dr. Ira Byock:** Well, those are the final thoughts, Chris. You just did it. I, I really, um, I want to get us past the denial and the demoralization. That I think is so prevalent within our field, this sense that we're already defeated, uh, the, the moral distress and the, and the burnout that is I, I see everywhere in the field, including in, in people decades younger than me.

I want to give them a sense that this is, that [00:58:00] this bright, beautiful field and our potential to really, uh, be all we can be, both for the patients and families we serve, but also to make, um, it possible within our mainstream culture to reintegrate illness and caregiving and dying and grieving within a sense of full and healthy living.

This paper, which again I worked on for many, many months, um, is, is hopefully a way to get out of the. The, um, fog of, of, of feeling defeated and, and, um, disempowered that I think is engulfing us. Let, let's shake it off and be proactive. Um, I really do think that this is, uh, a practical route path forward.

[00:58:51] **Chris Comeaux:** That is well said. Well, I want to thank you, um, again, my opening question about magnum opus or just the right thing at the right time. I do think it's a bit of both. [00:59:00] Not, not detracting from your

last book, but your, the heart and thought that you put into this and your intention, your intention behind it is for good.

And I certainly, um, it makes me uncomfortable in a good way, like. I now feel like I have to own this in some way, and I hope all of our listeners as well of like, you gotta do something with this. And so what are you gonna do with it? And I think about the patients and families we're serving today, the patients and families over these next, especially, you know, two years, three years, five years, seven years as the baby boomers age more because I do believe they're gonna ask for more.

Um, and surely living cause and purpose and making a difference in the world. I think of all of you, the wonderful patriarchs, matriarchs that created this thing at a very challenging time in our country when, um, death and dying was just not done well. Kula Ross and others and just bringing a very difficult conversation [01:00:00] to the forefront.

We've inherited all of that. And now what will they say about us 10 and 15 and 20 years from now? Were we the generation that shrunk from it? I hope not. I hope. I hope. And one final thing, I think I shared this with you off camera the first time. I'm a bit of a history geek. And so Tolstoy researched every civilization in the history of mankind.

And the, he said that the number one determinant about that civilization continuing is what they did for those who could not do for themselves, especially the old and the infirm. And, you know, we live at a time, our political discourse in our country is horrible, but, but the one thing that both sides agree to is the other side is trying to end our civilization.

Well, we are the common ground, so maybe we are the ones to come together and say it's the right thing for patients and families, our communities, but also maybe this broader context we exist in in our country.

[01:00:53] **Dr. Ira Byock:** Here. Here. Thank you very, very much.

[01:00:56] **Chris Comeaux:** Well, Dr. Byock, Ira, thank you for, for doing [01:01:00] this. And to all our listeners, I do hope you do something with this.

At a minimum, take it into your organizations. Well, at a minimum, start by reading it. Take the time to read it. Um, I sped Reddit 'cause like you, I, I just absorb a lot of material every day, but I knew when I went through it, I've gotta

go back and marinate in this. And I did that, put some time on my calendar, a good 45 minutes.

Um, I'm not a fast, fast reader, but you can do it. You'll be glad that you did, and I think it's gonna impact your work on a day-to-day basis. And you're gonna think about how can you be part of the solution as we go forward. This thing is too important not to. And again, thank you Dr. Byock.

[01:01:36] **Dr. Ira Byock:** such a pleasure. Thanks Chris.

[01:01:38] **Chris Comeaux:** Yep. To, to our listeners, thank you for listening to TCN Talks. We always wanna leave you with a quote and Dr. Byock, Ira, pick this. It's from EB, White. “I arise in the morning. Torn between a desire to improve the world and a desire to enjoy the world.” This makes it hard to plan the day. Why don't we work on improving the world?

Thanks for listening to [01:02:00] TCNtalks.