

Transcript: Private Equity, AI, and the Future of End-of-Life Care | Part One

Leadership Bumper And Quarterly Format

Melody King 0:00

Everything rises and falls on leadership. The ability to lead well is fueled by living your cause and purpose. This podcast will equip you with the tools to do just that. Live and lead with cause and purpose. And now, author of the book *The Anatomy of Leadership* and our host, Chris Comeaux.

Chris Comeaux 0:22

Hello and welcome. I'm excited today. Welcome to our TCN Talks Anatomy of Leadership podcast, my good friend Cordt Kassner here with me. Welcome, Cordt. Thanks, Chris. It's great to be back. It's cool to have you back. And so just to maybe refresh our listeners, because they're like, you guys had a rhythm in 25 and you've done something different in 26. So just a review, Cordt and I kicked off the beginning of the year, top news stories of the month. We did our predictions for 2026, which at the end of the year or beginning of next year, we'll actually come back and see how we did. Some of which, Cordt, you're probably like, hey, I'm doing pretty good. There are a couple I'm like, ah, I did pretty good on. Ah, gosh, I missed that one.

Cordt Kassner 1:00

It's fun to track it throughout the year.

Readership Surge And Subscriber Growth

Chris Comeaux 1:02

It is fun to track it. So what we've done is we kicked off the year that way. And then one of the things that Cordt and I, as we brought Dr. Byock at the end of last year, is a gift to all of our hospice and powder care listeners, people doing the real work on a day-to-day basis. Court and I had this idea afterwards and said, what if we use Dr. Byock's framework, his strategic framework, to drive our conversations throughout the year? And so that's kind of what we've been doing. You may not have realized that. So we kicked off January, and then we're bringing outside speakers that put meat on the bone related to Dr.

Byock's framework. So the measures that matter, we actually had Bob Tavares, uh Robin Heffernan, Mindy, Mindy Stewart Coffey, that were a part of the Measures That Matter initiative with Bob. And so, and that was all around standards and quality and data. So you can see how that connects a Dr. Biox framework. And then we brought the GeriPal guys, actually, which was kind of cool. It was a podcast within a podcast. And we did use Dr. Byock framework. Of course, they asked some questions as well. Um, I got to talk about leadership. Anytime I get to talk about that, that's pretty cool. But then each beginning of the quarter, so this is Top News Stories of March airing in April. Cordt and I are gonna come back and do what we did last year, which is top news stories, but we're gonna do it over the quarter. Now, do not lose sight every month. Cordt and I are actually including links to he's got his data, and I've got the articles that I'm flagging as Chris. So, what I'm gonna do today is I'm actually gonna look back over the last quarter, the ones I wanted to highlight, and then Court's gonna do the same and talk about some of his stats. So, Cordt, do you want to talk about your stats first? And then that'll give us a good jumping off point where we could kind of go into um, then we'll do mine, then we'll do yours. Sound good?

Cordt Kassner 2:44

Sounds perfect. So here we are in March. This is like people coming out of hibernation, is what it feels like. We the spring is here. It's been amazing. This month was really nothing short of remarkable in terms of hospice and palliative care today readership. We released 294 articles, which is pretty normal, that collectively drew 170,000 reads. And the last couple of months, we've been averaging around 105,000. So this was a huge jump. And some of that has to do with the content, the MedPack report, the Alliance releasing facts and figures, which were our top two most read stories. But but still, it was a huge jump in in the number of reads. Even more telling, we had 62 individual stories, each surpassed a thousand clicks, twice as many as last month. So this surge signals that certain topics are hitting home with you, our community of providers, clinicians, policymakers, and advocates. We're also thrilled to announce that our subscriber base has grown to 2,400 readers. So thank you for being part of this vital conversation. Whether you're at the bedside leading a program or shaping policy, your engagement helps us move forward. And please encourage your colleagues to subscribe to Hospice and Palliative Care today. It's free, it's a daily environmental scan of what's going on in our field.

Chris Comeaux 4:14

Well said. And congratulations, Cordt. I'm not surprised you keep doing the right thing, and I think you're going to keep gaining traction. And so hopefully, not too distant future, you'll see 6,000 plus subscribers, which means on average you'd have about one per every hospice agency throughout the country.

Cordt Kassner 4:29

So exactly.

Chris' Article Picks For The Quarter

Hospice Funding And The Expectation Gap

Chris Comeaux 4:31

All right. You want to jump into mine? Please. Yeah. So let me just give a quick fly over looking back over the first quarter. So January, I flagged 56 articles. February, I flagged 54 articles, and then March I flagged 39. So, no, I mean, it no deference that, oh, well, gosh, those seem like lower numbers. Um, I'm just trying to be more discerning of what we actually bring to our listeners. So the vast majority I'd like to highlight is coming from March, but there are a few I wanted to go back into in February and January. So let's pull from March. Um, this was a New York Times opinion piece. A lot of people reached out to me, like, what are you gonna do about this? Um, it really, and first off, I mean, kudos because it was from someone who it was a guest essay, someone who just experienced hospice. And here's just a quick excerpt. When my siblings and I decided to put our father in hospice at his home in the spring of 2021, his Alzheimer's was near end stage. He could barely get out of bed, dress, or feed himself. Hospice care seemed to be the best way for him to end his life with dignity. We soon encountered a harsh reality, however. Dying at home is easy, even with hospice care. The main problem was funding. In 2024, the average per patient Medicare payment was about \$200 a day with an annual cap of \$33.5. The outlay would barely pay for a part-time aid, yet it's also needed to cover medications, medical equipment, and nurse visits. So it really did kind of point to the original vision. Um, according to you know, the even the logic behind the actual reimbursement was not even to reimburse us for things like volunteer coordination, bereavement care, the methodology by which it came, and certainly has not kept up with inflation, especially the last five years, as we've been in, I won't call it hyperinflation environment, but certainly much higher inflation than we experienced, at least prior into my career. And so it's not kept up. Um, and then this family was just lamenting, it did have a tinge, and I can't wait to hear your feedback too, and I kind of thought hospice was going to take care of everything and didn't realize how much we were gonna have to do. And that's interesting because you know the model has always been about empowering the family and the caregivers to being a comprehensive model to doing that. And here's why it's a little concerning to me as we go more into the baby boomers, are we going to encounter more of, well, this is what our expectation and this is what you guys are about? We thought you'd just come in and take care of everything. So, do we have an expectation gap between um what's now becoming the sandwich generation? And then the sandwich

generation is even going to become some of our patients going forward as the baby boomers age out more and more. And recently my father-in-law had a pretty serious health circumstance and just is giving me a front row seat. Um, thank God for my wife, who has stepped up in a beautiful way for her dad, that's the family member. And I was thinking, man, a lot of families don't have an incredible caregiver to stand in the gap as we go more into the baby boomers. So I feel like there's some storm clouds that are kind of been an earth in this New York Times opinion piece. Um, funding is not kept up with the model. Is the model keeping up with what the expectations of the baby boomers are gonna be? Now, I'd also kind of push back on myself, I still think hospice is one of the most brilliant models of healthcare ever devised. And when it is deployed well by a high quality program, it does amazing things. So I'm not ready to throw the baby out with the bathwater, but I think it raises some interesting questions.

Cordt Kassner 8:03

You know, I agree. And as I reflected on this article, it really made me think about the two sides of the coin. Hospice, one side of the coin is that hospice is the gold standard of end-of-life care. There's no doubt about that. We we do more, better, more comprehensively, interdisciplinary team. We we set the stage for difficult conversations and and do things that that the rest of healthcare it kind of lacks. And and and for that, we we can stand in the sunshine and pat ourselves on the back, and this is a good thing. The other side of the coin is I I had an experience with hospice last year when my mother died. And and it it brought home some of the gaps in care that hospice, you know, on one hand, there are gaps that hospice says it does and it doesn't. And there are just gaps that it was never really intended to cover. And so we see the growth in caregiving and doulas and palliative care and these other areas that complement and come in and help fill gaps that that hospice doesn't do. So it's really looking at both sides of the coin. You know, we're so appreciative of what our hospices do for half of dying Americans across the country. And on the other side, there are some gaps. And it across the best hospices, there are gaps in care that really lean on the family members and external caregivers to fill those gaps. And this article, I think, just obviously this was leaning on the gaps side of the of the coin. But we need to hold both in tandem and figure out how we can continue to do this better.

Chris Comeaux 9:55

You think toward those gaps? I'm kind of inferring what you're so you push back if you disagree. Um, is that gaps mostly the fact that it's not there really someone 24-7 supporting, you know, the caregiver themselves maybe 88 and the patient much older? Or are there other gaps that you're alluding to?

Cordt Kassner 10:12

I I think there are other gaps, but uh, but I would in a general way frame it around setting expectations that at the admission process, you know, we are gonna be here. I and I again, I will use my my own case example. My mom was in general inpatient care for 20 days, and I was told numerous times, we will be there when your mother dies. If you're not there holding her hand, we will have somebody there. No one dies alone. And and so that expectation got set. So when she died in the middle of the night, it it you know, on a weekend, of course. Guess what? You know, she she just passed during the the nurse's chefs, you know, during rounds, and and there was nobody there. And that some of the other services, the volunteers, the social work, the chaplain was given was kind of an interesting story, missed the expectation that were set. The nurse was amazing. I and I'm not complaining about it, um because we're in the field, like we have conversations with with all of these folks. But when I talk with other people who've been in hospice for decades, my experience is very, very common. That that it it it meant, the actual care and service that was provided missed the expectation of what we thought was gonna be there.

Chris Comeaux 11:37

Kudos for you for thank you first off, because now I feel awful as your friend. I'd never pushed in further. You've alluded to it, and I felt like it was a sensitive area. You know, there is something interesting in a podcast with uh actually it was in the green room, it wasn't the podcast itself. Um one of our well-known folks, I'll leave her nameless, but well-known person has been in hospice from the very beginning, said, in the early days, we debated like there's like literal meetings, they were throwing chairs at each other because they were so passionate about the debate of what we do. And then the fact that Dr. Byock says that collegiality ends at criminality is kind of an interesting commentary of where do we lose the ability to have a frank conversation with each other? It's like which I think it's probably also the spirit of the age we live at the time, what corner are you red, are you blue, whatever? But I I love the fact that you just say there's something we should be talking about. Like, and and you know, there is the SIA. There, there's no more data now telling you we're in that window. And so it's either like, well, is your hospice perfect or is your hospice totally crappy? There's stuff in the middle that if we have good debates and conversations, it's gonna ensure that we keep doing better. And you know, I'm sorry to take it back to Dr. Bayok, but I really feel like that's what he's poking on is to say, hey, I'm worried about this stuff. We should have frank conversations. So kudos to you for bringing something up that I think you're inspiring me to kind of take that even back to the hospices we work with and say, how are we doing with that?

Cordt Kassner 13:00

Um, yeah, you know, I when we got involved in hospice years ago, I I remember saying over and over, hospice is 95% angels and five percent horrible. Uh not that hospice is

horrible, but that's the situations are untenable. And now, I again, based on my experience, but talking with so many others, there's a there's a pretty big percentage of pretty okay hospice. Yeah, like it's it's pretty okay. It's it's not golden angels. It wasn't horrible. And I don't even know how to put a number on that, but it yeah, that that segment never used to exist, and now it's a uh I think a pretty uh substantial part of the equation.

Chris Comeaux 13:46

Um, and you know, I've I've just I've just gotten reintroduced or just become more passionate about Jim Collins again, and he's actually releasing a new book. I was actually part of a group that got to hear his unveiling and talk about it, but you know, it's really what he was poking on with good to great, is that good has become the enemy of the great. I wonder if we've kind of fallen into that that we've heard we're angels for so long, but then we've also had these horrible fraud situations in California, which is not even in the same realm. Like what you're alluding to ain't that, because that's not even that shouldn't even have the name hospice, some of that stuff. So that almost becomes a distraction, but then unfortunately becomes part of the national news. Are you kidding me? There's a hundred licensed agencies as one address in California, and that becomes sensationalism. It's not that's not even that's you're damn right that should be fraud, it should be called out because this is really the stuff we should be talking about of really becoming great as we go forward.

Cordt Kassner 14:39

Absolutely. Well, we've got a lot of ground to cover, but I think this was a really important place to start.

Healthcare Prices And Hospice Spillover

Chris Comeaux 14:44

I agree, and again, thank you, and I my apologies to you and your family. So the next one I want to call out, Cordt, the U.S. healthcare spending problem is still about prices. This was a health affairs article, and just lamenting, it's the price is stupid, is basic one of the taglines. Central insight remains true today as it was when it was first articulated across services, drugs, inputs. This harkened me back to our podcast with Rita Numeroff last year, and I gave her the microphone and said, Hey, RFK calls you. How would you fix it? This was part of her key platform, if you will, of how you fix healthcare. And you may go, what do we care as hospice people? Because we exist in a broader system that's pretty screwed up. And as we try to fix the broader system, I want to make sure we don't get impacted as the whole Titanic gets reshuffled and then we get impacted because we

weren't part of the conversation because they're like, well, you guys need to fix all of healthcare. We got the hospice and pal to care thing, if you will. There's a great, in fact, we might even include a link. I love the healthcare A-to-Z guy. I wouldn't even call them their podcast. They're like little 10-minute educational videos. And he goes through the payer mix of the vast majority of, especially healthcare systems, and why does it matter? So here's kind of the punchline. Usually they charge ballpark 400% of Medicare to the commercial insurance companies. Medicare, maybe you're about break even, and then Medicaid, you're in a lost situation. And you make it work because of the markups on the commercial insurance that they negotiate that, and then they're kind of okay with the Medicare and they don't like the Medicaid, but you know, if they're a nonprofit healthcare system, they serve the community, so they accept that full mix. If it's a for-profit um healthcare system like HCA, they try to go much more for that commercial population and shift their payer mix. It just shows how screwed up healthcare is. Like you just look at that and go, where does that make sense? That, okay, we're gonna go buy a car and we're gonna negotiate 400% of the price for certain segment of the population. We're gonna sell that same car to other people, and then we're actually for the very low-end people, we're even gonna sell it at a loss. Nobody does that, but that's healthcare. And then the spillover impact and so many other aspects. And so it is why I've at least been passionate to bring people like Rita to go, we've got to fix healthcare at our broader level. And then how you position hospice within that, we damn well better be at the table and be knowledgeable about the broader shift that's gonna occur so we know how to position ourselves. And there are a lot of people, in fact, I'm gonna call one out. AMGA is like, hey, just make end of life all of value-based care. I'm like, what? So I'm gonna diss on that one, but it's a perfect example of if you're looking at just a small sliver and not looking at the broader context, we may end up in a place we don't want to be going forward.

Cordt Kassner 17:37

You know, this is uh such an interesting conversation. I if we focus on the pricing piece, uh like you say, the different prices for a car, or in in my own experience, the different pricing of medications. Like how different, and and we know that medications fall under the bundled payment for hospice. So if a hospice A is paying \$100 for a medication and hospice B is paying \$10 for the same medication, how is that possible? But it is possible. And and that whole discussion around pricing, not just of medications, but across healthcare is such a controversial issue because there's not that that equity. It's it there's not clearly defined this medication costs \$50. You're paying more and you're paying less. There's but we don't know what that baseline is. So the pricing is one thing. Uh I think the other piece of this is is the pendulum between mission and money. And you know, I everybody needs to make money to keep their doors open. I get that. Uh it's it's how far you go. Like, do we need a 50% profit margin in hospice because some hospices have

that? Like, is that it's it's how we have that discussion, how we want to think about the financial realities of providing this care.

Top 50 Providers And Fragmentation Debate

Who Owns Hospices And Why

Chris Comeaux 19:10

Yeah. I'm gonna go there in a little bit. I've got a couple articles I'm gonna call out to that. All right. Well, I'm gonna move along here, and I think you had a part in this one. The hospice news 50, maybe I assumed you did, but last year at least you participated. Hospice News Provider Rankings and Annual Trends Report, the second annual hospice news provider rankings and trend report. Basically, it ranked the hospices, the top 50, based upon revenue. In 2024, there were 6,685 companies that filed Medicare claims. That was up from 6,343, so an increase of about 20%. Um, and so, and the largest 15 providers of that report accounted for 20% of all hospice locations and 35% of hospice patients nationally. Now, at first blush, you may say, wow, those guys covered 20%. And this is where, and I know I'm gonna get some calls from some of my for-profit friends. I'm looking forward to it, guys. Give me a call. But here's some things I'm gonna call out. Software in software as an industry, their top 10 to 20 represent 50 to 80 percent of the total market. Banking, 50 to 75 percent, the top 10 to top 20. Accounting, the top 10 to 20, represent 70 to 90 percent of the total market. Okay, Comeaux, what's your point? We're still a very fragmented market. Well, then the private equity folks will say that's why you guys need to be consolidated. Not so fast, mister. There's something about this model that's brilliant in the way it was designed. And I do think we're going into a very interesting time because of AI. A little bit of a rabbit trail. Um, Jeff, our executive producer, has turned me on to the diary of a CEO. So it's one of my favorite podcasts I listen to weekly. They had a really great podcast recently. He's really on the AI bent because he's like, you know, I bring great people about health and wellness and kind of got that stuff figured out. Don't know where AI is going. So he brings his thought leaders on related to AI. One of the folks was talking about, we're going into a place where probably the high performance organizations of the future might be the 10 to 20 small organizations that are very niched. Whereas in the past, because of knowledge, it was large corporations. So if the trend going forward is smaller, and guess what? Hospice has always been smaller because it's actually high touch, it's not high tech. And yes, we should utilize technology thoughtfully, like when do you show up for an SIA, as Cordt was talking about earlier, um, when you're in those last seven days of where you need more intensity. So I think it's a good thing, and hopefully that trend even becomes less, that it's more diffuse because you can bring more specialization, the call of high quality and where the future goes, and

create great programs. And you don't have to create this huge consolidation to create interesting innovation. I am working on that. Like, you know, keeping these small programs independent, but get them some of that leading edge thought process. That's so obviously I'm biased. I'm going to own it. And again, I look forward to my friends who are going to call me and take issue of what I'm saying. But I do think we live at an interesting crossroads where the past was, well, why would you become part of these large for-profit entities? Where are they going to bring all this great knowledge? I'm sorry. I actually know behind the scenes a lot of what they're working on ain't any different than what we're working on. There's no one that's figured out the perfect mousetrap related to hospice and powdered care. The for-profits are just a big marketing thing as far as I'm concerned. And now maybe they're like, oh, you don't know what we're working on behind the scenes. So please call me because I'd love to hear about that. So, Court, what do you think?

Cordt Kassner 22:52

You know, I I approach this particular article, and yes, this is the second year that hospice analytics has contributed to Hospice News uh story about the 50 largest hospice chains. Uh and I approach this maybe from a little bit different angle, which is how incredibly difficult it is to identify hospice ownership. Um there are hospice chains, Vitas, for an example. Every Vitas hospice begins with the word Vitas. It's very easy, it's very clear, it's very transparent. I really appreciate that they make it very easy to aggregate all of the Vitas locations under one umbrella. LHC Group, as a different example, has a whole bunch of hospices across a whole bunch of states through mergers and acquisitions, and they've kept all of the local names. It's not LHC Arcadia, LHC Charleston, it's whatever the local name is. And that makes it very, very challenging to actually identify who that corporate owner is. And one of the so I've been tracking this for probably six years now, identifying that and tracking all of that merger acquisition activity in order to roll up CCNs to identify hospice chains. And I think it going back to your early stats that you were talking about, very relatively, very few chains account for an enormous amount of the field of the provision of hospice care nationally. And I think all of our independent providers need to remember that. So that when Medicare comes out with a rule change and they're like, oh, this is stupid, this is targeting me, it's not targeting you. Like there is a target, there is a data-driven reason. Medicare goes in the directions they go, no doubt about it. But that solo independent hospice provider in a in a small community or a large community, that that is not representative of what hospice looks like from a national lens when Medicare looks at hospice. And and to me, this is a reminder that we've got to have a clear understanding of how hospice fits into Medicare, into health care, into America. And often we focus on our specific niche of it when it's part of a very comprehensive system.

Total Cost Models And Protecting Hospice

Chris Comeaux 25:37

Well said. Yeah, makes it very complicated. All right. So another one. AMGA calls for total cost of care model for end-of-life care. So um I didn't know about the AMGA, the American Medical Group Association, is that CMS, and basically came out and said CMS should establish a total, a total cost of care model for end-of-life care. And so I read the article and I can see their perspective. So kind of picture a lot of primary care docs who are going to be more at risk for total, and they're basically lamenting the current model. This is where we've got to get very precise with our language. So I would push back, and I'm like, first off, well, before I push back, I should step back and say, wait a minute, these are people referring. So why do they feel like the current system is broke? This is my read is that the challenge quite often, right? We know because we lament this, we have to go in and have the tough conversation because they can't. We could, you know, diss on them all day long. They have so many, they have a huge patient panel, but that's what we're there for. It's the step and the gap. But the gap is what I feel like they're lamenting. So I feel like what maybe if you took what they're recommending at face value to meet, it applies to the palette of care, serious illness space, and that be careful that what they're like if someone just took it and went ran to RFK and said, this is the answer, hospice could get wiped out. You erase that line of what hospice is today, which is still a brilliant model of healthcare. When reality is what I think they're speaking at is basically the gap before, the real palliative care gap. And I love that you so many, many of you listeners have seen the two triangles before where it shows aggressive curative care and the triangle of powdered care, and you're getting a less aggressive curative and more palliative, and then you get that referral to the rectangle at the end, which is hospice, and then you got bereavement, and then there's more sophisticated models. But it's a great simplistic way to talk about that palliative care is in that concurrent care messiness space. And I think that is a space where we do need to see a lot of innovation. But if that innovation erases the line of hospice, and there's some well-known consultants out there would basically say, What it just needs to be innovated. Be careful innovation for innovation's sake. And like one of the examples is the landline versus the cell phone. I'm sorry, I still think that there's a lot of value in the hospice model. The the um election of the benefit and that people are reconciling their own mortality and all of the hard work and how we walk alongside them. If you just erase that line and just make it, I have a friend who calls it the marshmallow or the blob, uh, the marshmallow or the blob, which is again what I kind of feel like this article is speaking to. And and maybe most of those people just don't have the benefit of great hospice partners and they just feel the weight of the burden of managing these complex panels. And so that's my opinion. It's a very strong opinion, a very well thought-through opinion, one of which I've debated many people on this podcast and will continue into the future. But if I was king for the day, I would advocate

you keep the hospice benefit. No, we shouldn't have two and three-year length of stay. We've got to get better at that prognostication. And it really is more of a six-month benefit, which, you know, hopefully that's where we could apply technology, and you chassis it to innovations like a palliative care model, which needs to be funded different than it is today. And then maybe other innovations like PACE and home-based primary care. And that's the innovation space chassis to one of the very original managed value-based models, which is called hospice, and has saved millions, if not billions, of dollars. So be careful in the innovation that you actually don't kill. I've used the analogy before, Stephen Covey, the goose that lays the golden eggs. You know, they they killed the goose to open the golden egg to get all the eggs, and they didn't realize, oh my God, we killed the goose. It worries me that that could be hospice in the look for innovation.

Cordt Kassner 29:31

You raise a great point with it. To me, it's it's clearly articulating who's responsible for what and identifying where those gaps are and filling them. Uh hospice fills many gaps from the the acute care setting. Well, hospice has its gaps too. And how do we clearly set those expectations? Uh our our healthcare system has uh is it's very fractured. It has a lot of growth uh to actually take care of patients. And and I would expand that to the family members, the caregivers. Uh, there are many gaps, and and this is one effort to identify and and address some of them. Uh, but I I completely agree with you, Chris. We need to be very thoughtful in the innovation that we're promoting. It's there are unintended consequences.

AI Consciousness And Human Purpose

Chris Comeaux 30:26

Well, those are all of mine for more. So I'm going to hit the last ones very quickly. So February just had a few, but this one really caught my um my uh attention because of you and I's predictions. Uh this this was the title, Existential Risk, why scientists are racing to define consciousness. As artificial intelligence continues to advance, ethical concerns grow alongside it. Scientists said the need to understand consciousness has reached a critical point. So if you remember, Cordt, you and I talked about that in the beginning of the year of we're gonna have to answer what does it mean to be human? Because if, you know, basically this they said once we hit re- hitch AGI, um, they said picture, this is a perfect analogy. I think it was in the diary of a CEO, picture an island with 14 billion uh geniuses all in the same place, and they could teach each other all at the same time that that's basically what we're we're we're headed towards. So then what does it really mean to be human? And if you remember, I theorized out loud, could we teach the AI to help us with advanced directives? Because at the same time, we're teaching the AI please don't off us

like Terminator the movie. Um, and you know, we embed John Connor in the system. So I love I just call out this article was in the published in The Frontiers of Science. I think that's gonna hopefully reach a bit of a crescendo. What does it mean to be human? Um I can't remember what podcast it was I was listening to, but music that's generated by AI, even art, there's something about the soul that comes out in things that we produce. Not that the AI produced things aren't good, but excellent things you still feel that imprint. And I know it may sound wispy or whatever or woo-woo, but you could tell the difference between a song that is just masterful compared to some produced by AI. And this reminds me, Cordt, my mentor, Dr. Thayer, one of the last blogs he wrote, which is probably was 2016, I think. I think somewhere in that ballpark, 2015, 2016, was Oh my, the robots are coming. And he said this if your job can be replaced by a robot, it should. And what he was basically, he was all about virtuosity and mastery, that if you are doing mastery, you can't be replaced by a robot. And that to me was a calling, and this is what I'm all about. My book, The Anatomy of Leadership, Calling People to Cause and Purpose, I think is actually the answer to their question. People living in their purpose, as opposed to someone pushing the button of a job. I don't know what the hell my job does. I don't know what happens when I press this button, but you know, they pay me for it. Unfortunately, that is a good portion of people's lives. And that is sad. That is what you want AI to produce or to replace. So what you do is maybe what the only reason why you are on the face of this earth. And well, what is that? Hey, those are the things we should be wrestling with, and hopefully we're doing more of into the future.

Cordt Kassner 33:20

This this article and what you're describing, Chris, just reminds me. Yesterday I I popped into a a virtual meeting of the University of Colorado palliative care team. And University of Colorado is where I began my professional career. And and I thought, you know what? I want to go back. I just it was a review of the palliative care research they're working on. And I thought, I just want to, I just want to tune in and and see where they're at today, right? I I'm so proud of the work that they're doing, and and as an early, early member of helping support getting those efforts moving. Uh it's amazing. So Jean Kutner presented on the Ascent project, which is incredible.

Chris Comeaux 34:02

Um Jean actually on that.

Cordt Kassner 34:04

I'm excited for that. I think that's gonna be just amazing. Uh, but then they talked about all these other research uh projects that that the team is working on. And where I'm heading with this is they're very pragmatic and clinical and concrete and researchy, right? I found myself just kind of thinking about the ethical implications, going back to the

whole just because we can, should we be doing X, Y, and Z. And part of their research is addressing those ethical implications. And uh, how do we define consciousness and what does that mean? And there's a there's a I think that's a whole different conversation. And I'm glad that you highlighted this one because it it just brought up the ethical side for me to to really dig deeper into why we're doing what we're doing, is what we're doing the right thing. Um, so I love that.

Jeff Haffner 35:02

Don't miss part two of this episode coming this Friday.