Transcript: **This Global Healthcare Lesson Could Change America | Part One**

Leadership Theme And Welcome

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 0:23
Hello and welcome. I'm so excited today. We have a special guest, Dr. Mark Stoltenberg, who's an attending physician in the Division of Palliative Care and Geriatric Medicine at Massachusetts General Hospital, and he's an assistant professor at Harvard Medical School. Welcome, Mark. It's so good to have you.

Dr. Mark Stoltenberg 0:39
Thanks a lot, Chris. I'm really happy to be here.

Chris Comeaux 0:41
Yeah, let me introduce you. I know there's some folks, especially then kind of the nonprofit hospice side, know about you, especially. I got to meet you recently at our NPHI National Partnership for Healthcare and Hospice Innovation Conference. And I went right up to you. I'm like, I'd love to have you on my podcast. But let me introduce you to a lot of the folks that are in our listening audience. So, Dr. Stoltenberg is palliative care physician at MGH and Harvard Medical School, where he serves as the medical director for the MGB Home-based powder care program, and he's the co-director of the MGH Global Palliative Care Program. Dr. Stoltenberg's work focuses on innovative collaborative models and methods of responding to the suffering of the most vulnerable, both locally and globally, which is what we're going to focus our time today on. He has led palliative care projects across the Caribbean, East Africa, Latin America. He's worked as an international consultant for the Pan American Health Organization, P-A-H-O, and the International Atomic Energy Association, IAEA. And he currently leads a subgroup for the World Health Organization, WHO Palliative Care Working Group. So, Mark, again, it's such an honor to have you. You're such an amazing storyteller, which I'm looking forward to you doing today. And I kind of warned you I was going to do this. And we ask all our

guests. It's a I feel like it's a special question because I get to see it in action as people talk throughout the podcast. So, what is your superpower?

Mark’s Superpower And Vision

Dr. Mark Stoltenberg 2:08
Uh fun question to get us started. Um, so it's a good question. I think uh if I had to think about it a little bit, a piece that I've had since probably quite young and through college is I really like thinking about what could be and dreaming about the future. And so I think now being in a space with palliative care, I think there's so much opportunity and I've had the opportunity to experience so much creativity and innovation around the world that I think my superpower is I love asking the, well, what if, or why can't we? Um, and then I have lots of colleagues and friends that bring me back down and okay, well, how are we going to concretely do this over the next three to six months, which I enjoy? So I think the connecting those two things. But if it was my superpower, it's I love dreaming of a future that could be a little bit more equitable, a little bit more fair, a little bit more abundant for all. Um, and I love sort of playing with those ideas with others that want to get into the sandbox.

Chris Comeaux 2:56
That's so cool. I was actually talking to my wife this week, and I don't know if you'll identify with this. Do you remember who Don Quixote was, the whole story by Cervantes? And I forgot even how my wife and I got there. And I was talking about like the incredible wisdom of Coyote is that he was an idealist. And that while people say, well, he's crazy. No, he had this idealistic view of the world, which in many respects called other people up. And she looked at me and she goes, how did you get that out of that? I'm like, well, it was actually part of my master's leadership. And she's like, I just thought he was kind of crazy. I'm like, well, a lot of people that actually push the envelope, quite often they are kind of called crazy at a certain level. So, I don't know if you identify with that at all, but um, I wouldn't, I wouldn't have uh said, you know, definitely not saying that Mark is crazy, but I feel like you have that beautiful visionary, um, kind of pure heart about you. Like I could just see that. Again, that's why I was kind of drawn to you. And I got to hear you at we had a pre-con for MPHI at Notre Dame. Got to hear you speak there, and I got to hear you speak at MPHI, and you're just a great storyteller, and I can see that superpower in you, that visionary aspect. And feel like it's coming from such a good place within you. So if I can mirror it back to you, hopefully you take it as the compliment it's meant to be.

Dr. Mark Stoltenberg 4:08

That's very kind, Chris. I appreciate it.

Chris Comeaux 4:10
Awesome. Well, let's jump in. And so, I can't wait to talk to you about this because again, just seeing your work globally, you're doing amazing work stateside, but also globally. So, you've worked in powder care across very different healthcare systems and cultures all around the world. And I'll also talk about, you know, when I saw you at Notre Dame and you talking about the work that you were doing globally, there is a side to me that I've always honored and respected and almost revered the matriarchs and patriarchs that created this thing. You know, I never I never realized that when I was 13 years old, this thing called hospice was being birthed, and then being part of an organization at Four Seasons was on the forefront of palliative care. This beautiful field now exists, which was just frontier in like the 80s and 70s. But I feel like that same spirit is out there globally, and I feel like you were reflecting that. So, I don't know, I don't know how accurate that is, or if I'm just being Don Quixote here. But what have global communities taught you about the essence of powder care that perhaps we in the US maybe overcomplicate or maybe we've lost touch with?

Dr. Mark Stoltenberg 5:19
Yeah. Um, no,

Palliative Care As Social Justice

Dr. Mark Stoltenberg 5:20
of course, I think you're reading that exactly right, and that has been my experience as well, both here in the US and having the opportunity to meet some of the founders that created this field for us, and then especially globally, where I've been able to see that. So, I would say a couple of things. So, I think one, absolutely the seeds of palliative care. So, I have had the opportunity to meet a lot of the founders of palliative care for different countries, the people that just saw something and decided they were going to do something about it. So I think the first thing that I would say is there is a social justice bent and a very strong moral statement at the seed of why palliative care grows, why it started with Cicely Saunders or the modern hospice movement in the UK, the folks that chose to bring it here, that same thing if they saw suffering and decided this is unacceptable, many from their own inherent value system, many were religious, many were not. Um, but seeing there is something inherently wrong about not optimizing the dignity of these patients, even though we can no longer cure, we can still care. And I think that same sort of moral choice to do something about the injustice that they were seeing is at the heart of a lot of these incredible leaders. So, I would say that's one thing I've

learned is this is a story. So ultimately, we talk about how do we define palliative care? It is a response to suffering, period, full stop. I think that's what we sometimes miss is that looks different in different places depending on what the epidemiology is or what illnesses they're suffering with, but also culturally how they suffer. Is it more in families? Is it more in communities? And then what resources are available to respond to that suffering. So if I had to say one key thing that I've learned that can be applied here is um over time, all of those initial reactions to the need need to be institutionalized, need to be grown. That's not a bad thing, but it can then start to become well, what is hospice? Hospice is writing the coding and understanding if patients are declining so they can, and we get locked into this is the structure. So we think that's all it is, and we need the structure. It's this very important sort of push and play. Um, but ultimately we can't lose sight of what the moral vision was at the heart of this. And I think that's what can keep us powered to like the future of palliative care here. And also that's the thing I get to be rejuvenated and see every time I get to meet these global leaders.

Belize Story On Presence And Dignity

Chris Comeaux 7:31
That's so good. Um, you whenever I think I think you did it at both at Notre Dame and the National Conference, but you told a story about a lady, I think it was in South America, and I felt like you were telling the story almost of like another version of Cicely Saunders. Would you mind just sharing of course? Yeah, that's awesome.

Dr. Mark Stoltenberg 7:48
So this was my entry into global palliative care. Um, I've embarrassed her many times, so I will look forward to sharing the story again. So this was I was just finishing my family medicine residency and about to start palliative care fellowships. So I didn't know a lot about palliative care yet. So it's Dr. Beatrice Thompson, who was the founder of palliative care in Belize, so in Central America. Um, and so I spent a month with her back in 2015. Um, and so there was one patient encounter that I'll never forget. So it was a patient from the south side of Belize City, so a poorer part of the city. He had a really terrible head and neck cancer. There was no more cancer-directed therapies that could be offered. And she had been visiting in him in his home for the past number of months, and she took me with her. And we had to walk through sort of like a swamp, and there were planks to get over the swamp to get to this house that had sort of a partial roof, and he was all the way back in the corner. The wound had started to be getting infected, and so there was a smell in the house, and so a lot of the family didn't want to be near him. And Dr. Thompson just walked in, sat right next to him. She's about five foot nothing, um, but one of the fiercest women that I've ever met. And she just sits down, plops right next to him,

and looks at him and starts talking to him about his day and how he's feeling in this matter-of-fact, calm way that immediately his inherent dignity just became illuminated because of her commitment to him. And I just sat there watching it in awe. And every time I think, what does it mean to be present to a patient? To this day, I still remember that visit.

Chris Comeaux 9:09
That is so beautiful. You know, I was I think I said this out loud at Notre Dame when we were there together. I'm a bit of a history geek, and I believe it was Arnold Toynbee, T-O-Y-N-B-E-E. Our listeners could check me on this. And so he had done research on every civilization in the history of mankind. And he said this was the number one indicator on whether that civilization continues or not. So think of the profoundness of what I'm about ready to say. Do you know that number one indicator is what that society did for those that could not do for themselves, especially the old and infirm. And so for me, when I read that as a young man, and then two years later fell into hospice, I never forgot that. I feel like we're doing this work that's not only, I mean, you think about that's just beautiful. That is so profound, the story you just told, and Belize, and then that occurring all over the world here in the United States, it's got profound impact for that person individually, but it also echoes into our society as a whole. I don't know if that feels true to you, but you do so much work all over the world. Does that feel right?

Dr. Mark Stoltenberg 10:17
I 100%, Chris. I think uh that way of thinking is accurate. And I think now more than ever, with things that are happening in the world, we need that more than ever. And I think I truly believe palliative care, especially global collaborative networks of connecting across borders and across cultures to learn from each other of how compassion plays out and how care plays out, I think is one of the seeds that we can work towards to be a more peaceable society and better understand each other and go back to caring for each other instead of fighting and arguing with each other. Couldn't agree more.

Chris Comeaux 10:50
Well

Low Resource Innovation And Workforce

Chris Comeaux 10:51
said. Well, let's get in because I we've got a lot of interesting listeners across the whole spectrum. We've got folks on the for-profit hospice side, nonprofit side, and really, oh yeah, that Comeaux he is a Don Quixote, he's an idealist. Listen to him. I'm a CPA by trade,

actually. So, I grew up in the business world. So, there is a push and pull, I think, between this beautiful mission work, whether it's all over the globe, um, but we're also got a lot of storm clouds, resource challenges, etc. So, in many low resource countries, these powder care teams are forced to innovate. In fact, my mentor, a guy named Dr. Lee Thayer, always said that necessity is the mother of invention. These organizations globally lack funding, technology, workforce capacity. So, what are some of the innovations that you've seen globally that maybe we should be paying attention to here on the state side?

Dr. Mark Stoltenberg 11:43

Yeah. Um, so there's a bunch of things I think I could say here. So, I'll try to highlight two, I feel like the most important ones, but I think there are many, many more um that could be shared. So, I think the first and the piece I've learned the most and been the most involved with is workforce diversification. So, we know we there will not be enough palliative care specialists to care for everyone here in the US. Many of the countries I work in, there's not even one. Or maybe there's one or two for the entire country. So, I think that has forced folks, and together with our program at Mass General with many uh longitudinal partners, what what are the educational needs and how do you close that gap, recognizing we will not have multiple subspecialty training programs in a lot of these sites for another five, 10, 20 years? That's still a very important step. So, we should work towards that. But in the interim, there's a lot of patients suffering that need help. So, um I think one really important piece is thinking about the role and what the appropriate scope is for intermediate training programs. I think we often in the US, it's either a one-day webinar to sensitize people or it's a one-year fellowship. There is a lot of space in between those two. And there have been some programs that have, um, so there was the PSAP program at Harvard that was around for 20 some years back early in the early days of the specialty. Um, there are no different versions of it going on today. Um, but I think what we've worked with and I've seen is can we do a four or six-week course? Can it be maybe two weeks of in-person with six months of really six months of really intensive virtual support? And maybe there's a mentorship component. Can we take general practitioners or nursing leads for a primary care clinic and with really intentional, clear scope, what are basic palliative care um uh things that they can do, interventions that they can do independently? And then can we build referral networks and pathways that they can get the support when they need when it's a more complex case? So, I would say moving beyond the just you either refer to a specialist or we give you a one-day course for all the primary care docs, and really thinking about how do we build champions that become mini specialists or become very advanced in palliative care. So you have a cardiologist that can manage a lot of it for their cardiology practice. But when it hits the next level, maybe then it goes to the palliative care specialists. So, I would say workforce diversification and thinking more creatively about what we mean by primary palliative care. I think there are many other parts of the world and countries that have done a much more robust and

thoughtful uh structures for how to think about that. I think the second thing that I would say that I've seen is um we, so I would, in general, um, from a Western perspective, we are a lot more likely to focus on autonomy and to focus on sort of making sure that we're holding all of our own cultural backgrounds at the door to make sure that we're hearing the patient. Of course, I think all those things are really important. And one of the things that I've seen grow in other parts of the world is there are so our cultural differences can be barriers to hearing each other, but they're also resources. It's a cultural resource that a group of folks in Kerala, India, can provide care in a very uniquely Indian and for many of them Catholic, because it's a very Christian region of India. In Belize, it's a very Christian nation, and there is a piece of that culture that plays in. In Chile, it's slightly different. So, I would say the piece is I feel like they can give themselves permission to sort of develop that very unique way of caring that's rooted in who they are, as opposed to I feel sometimes we hold and keep that at the door. Um, of course, we should never be proselytizing or forcing our beliefs onto someone else. Um, so one example that I would give, I was just on our palliative care unit last week. Um, and so we had a patient um in the midst of transitioning from uh gentle care to more of a comfort-oriented care and getting home with hospice and trying to make those decisions. And she had just decided she was done and didn't want a lot more interventions. And that morning I was sitting with her looking out at uh the sun over the Charles River. Um, and she had shared with me and talked a lot about how she was Catholic, and that was a part of her story. I happened to be Catholic. And so in this setting, um, I looked at her, I said, look, if it would be helpful, would you want to say a prayer together? And she looked at me with watering eyes, saying, Are you serious? And we said that our father together. And it was something that was very, very meaningful for her. Of course, I don't do that with my non-Catholic patients and most aren't, but I think there is a way that we need to be sensitive, but also let our unique way of caring for others come out in what we do that I think is really

Project ECHO And Training Pathways

Dr. Mark Stoltenberg 16:07
important.

Chris Comeaux 16:07
That's cool. That's gonna be a good segue to the next question. But I want to go back because you were talking about the workforce. Mark, have you ever bumped into Project Echo? And so you're making, so we actually I feel like I need to go back. Dr. Bulls retired now, and um, you know, as the CEO, you don't error you're not able to get into the weeds on projects like now. This one, I've been having the sense I want to go back because we actually had a Project Echo grant. And my understanding of that whole model is like this

interesting hub and spoke way to disseminate knowledge. Is that thinking part of the solution? Because in in resource poor places, because that's actually where Project Echo, you may know better than me. I think it was in New Mexico where they needed more infectious disease doctors, and they couldn't have the specialists in these very remote areas. And so it was developed out of the necessity of that. I think, is that right?

Dr. Mark Stoltenberg 16:56
To treat hepatitis, yeah. So, we're actually a hub and we've been running echo programs um in the Caribbean and Latin America for the last six years. So, we know it well, absolutely. So that is one example of the sorts of programming. So specifically in the Caribbean, now for six years, we have a monthly Echo that brings the whole palliative care community and anyone who's just interested in palliative care. And we have one didactic and then one person presents a case. I was just getting emails for the case next week about it this morning. Um, so I absolutely think Echo is a wonderful example. So a country that's done this at a level that's pretty impressive. So, Uruguay has incredible access to palliative care across their public sector, and one of the key ways they've gotten there is they have two national ECHOs that they've been running for many, many years to support people to slowly build up those primary palliative care skills.

Chris Comeaux 17:41
Is there some um methodology by which you segment and build the curriculum? I'm trying to think of a good way to ask this, where like, okay, this is general skills that everybody needs to have, but then this is high-level specialist skills. Like, you know, I always joke that if God would have asked me, the Vulcan Mind Meld really would have been a cool human accessory. Um, like in the movie The Matrix, where we could shoot at each other. And apparently Elon Musk is working on that. But in the meantime, right, how do you take a huge body of knowledge and parse it out in such a way that you can disseminate it where it's the right knowledge, right place, right time? Is that part of echo at all?

Dr. Mark Stoltenberg 18:20
So I think echo is one of the tools in the toolbox, but it's not the only one. So I think what you're describing is often what we've tried to do with our partners in the Caribbean and Latin America. So, I think it's slightly different in each country. I think it starts with asking the question: what are the core competencies or entrustable um professional activities, is also in the literature that folks are talking about more, that we want a particular group of people to have. So, in Chile, for example, it was very clear they have had palliative care for cancer patients since 2003, mandated by their health insurance, which is pretty great. They advanced to in the past two to three years to provide it for non-cancer patients. So that was an enormous need for their primary care centers to know the basics of palliative care

to start to be providing palliative care. So we partnered with folks there to think about a multimodal way of meeting those needs. Part of it was a virtual support course, but then also there are now dedicated diploma courses through various universities in Chile that we're targeting. What are the levels that they need to be able to provide that basic um competency to deliver that level of care? Um, it looks slightly different in the Caribbean with the University of the West Indies where we've been partnering for a while. So it is different, but the question is what are the core things we need them to get? What is the minimum amount of time, either observership, virtual, or in-person teaching, um, and then setting that standard and partnering with local leaders to then build it.

Chris Comeaux 19:43
That's amazing. You no, you didn't mention the superpower of like is architecting curriculum part of your superpower out of curiosity?

Dr. Mark Stoltenberg 19:52
So I would not say it's mine. I would say maybe a superpower I have is I know my areas like this, but we're pretty good about building teams. So we have a number of wonderful colleagues we work with, specifically my co-director, Dr. BR Dobbin, who is an expert at doing that. So, she's extremely helpful with that. And then we partner with people in these regions and in these countries that are educators. Um, and so we really it's building together.

Chris Comeaux 20:13
That's very cool. Now, when you were talking about workforce, you I feel like you alluded to it, but you didn't say it specifically. I know that our mutual friend, John Master John, is super bullish on community health workers. And so, is that a particular discipline that you've seen very successful? Can you talk about that at all?

Dr. Mark Stoltenberg 20:31
Yeah. So um I will say unfortunately, none of the programs I'm directly involved with have we instituted this yet, but it is absolutely on the radar and absolutely in the global health literature, um, specific widely, and then also specifically for palliative care. Um, I think they can be an incredibly important part of the solution um for meeting the needs of patients, especially in the home, and especially when you're we're thinking about more community-based and rooted into the local.

Chris Comeaux 20:57
Very cool.

Spiritual Care And Family Decision Making

Chris Comeaux 20:58
Well, I told you I have a segue question. You're alluding to kind of more the spiritual component. So you've seen healthcare systems where family, community, and spirituality play a much larger role in serious illness, maybe than we do in the United States. Sometimes we check that part of ourselves at the door. What do you think that we can learn from these models about restoring the human connection and care delivery?

Dr. Mark Stoltenberg 21:21
Yeah, it's a great question, Chris. So I would say one thing that I have thoroughly learned from my colleagues abroad and have tried to bring back to Boston and when I'm practicing is again, I think we often in the hospital, when we're seeing a patient, we either assume, or some of our patients prefer, that dying is sort of an autonomous process, that it's up to you and what you want. And let's think that through and figure out how we can do it. And that is very important. And for many patients, that is how they would prefer it, and we need to meet that. And I think inevitably, in every case, even in isolated patients, the reality is dying is a family and community process. Almost no one dies completely isolated from any. And even when they are isolated, the prior relationships that they came from, their families, their friends, their community, often either come out to try to support to some degree, or the grief and the pain of if they weren't rebuilt in time as they were dying, I think comes back. So, I think a key lesson that I've learned is that dying is absolutely a community and a family process. And therefore, if a patient says I don't want anyone else involved, of course we will respect that. And I think we've seen over time the best outcomes are to what degree they are able to tolerate to have family involved, because ultimately what we see in the hospital, when you get them home with hospice, the family's going to start coming and having questions and participating in that process. So, I think the more we can involve the family, I think the most I've ever had in a family meeting is while I was in Rwanda was 45 people. Not saying we need to get 45 people in for every meeting, but I think there is a cultural piece that my colleagues from Rwanda will speak to that a recognition that this is a family process and even the decision making can be familial. So, I think that would be one piece. I think another thing I would say, um, so it's rare that folks die alone, but I do see it much more frequently in Boston than I do in almost any other part of the world. Um I think that is a symptom of our wider culture that we are a little bit less connected, we're a little bit less communal, and we do have a lot of patients that unfortunately do die quite alone. Um and I I also think palliative care can help point us in the direction of how to recover that. Um so I think where we can bring local communities together, bring resources that maybe there can be some semblance of connection or community, if not for the 20 years that they had in their fractured relationships, at least at the end, to recognize the value of being in relationship and the

dignity that can come from being seen and being valued by others. So I think it's happening, and that's a a wider culture that we're obviously not going to fix. But I also think we can be a small part of the solution of remembering what it means to be connected and be together.

Chris Comeaux 23:54
So

Loneliness And Rebuilding Community Care

Chris Comeaux 23:55
you probably know this. We had a group of us uh via NPHI that went to England, and I did not know that England has a minister of loneliness because loneliness is such an actual epidemic there. And Tom Koutsoumpas has talked about it and from the stage at NPHI, but I just think about that, and just first off, how sad that is. You feel like I feel like you kind of just alluded to the fact that powdered care in some respects could maybe be a bit of a light of you know, dying is where it's where it's maybe resource poor, the community comes around other people, is what I feel like you're saying. And that creates an amazing system where we might look and go, well, you know, we've got so many more resources than them, but yet stateside more people are dying alone because of just our whole society. Can you say just a little bit more about them? What could power care do about that? Like how can we be part of the solution of that societal ill that might be more of a symptom of more, you know, the industrialized first-world countries, I think is the right term.

Dr. Mark Stoltenberg 25:00
Yeah. So I think one thing I would say very sort of explicitly and clearly, I think we absolutely need both. So I think in places where the family has to come along because there aren't medical resources, ability to get the medications and things that they need, I hope for a future where in those places we can have great interdisciplinary palliative care teams and a family and culture and culture of community that folks can bring around. So, I think working towards a future where we have both is absolutely the goal. And then I think specifically for here, um, so I think there are examples. So,I think things like volunteer programs for hospices, especially for younger folks to get exposed and to understand that this is just a part of what we do. Um, there's, I'm trying to remember the name. I want to say it's an Omega project, but so this is a group of different housing where they just provide the housing and then they partner with local hospices, but as a way for folks that are needing routine level of hospice care that don't have anywhere to live. I've met with the folks that lead one of the programs in Massachusetts a year or two

ago. I think that's a beautiful way for the community to come together and make a statement. Um, and I think the other pieces, so I think there are unique ways where communities, so in the Chinese community or in the Jewish community here in Boston, or many of the other, there are unique cultural ways that I think the more we can be partnering with this diverse group, a sort of an ecosystem of caring that people can bring their authentic cultures and histories to how they care for each other and for others. I think uh that would be my suggestion. So, for health systems hospices, really trying to invest in those community connections. I know a number of their nonprofit hospices in the Boston area, care dimensions I know well, and there are others that really try and respect and bolster those community connections. I think that really matters. And so, I think really investing in your local community and building those connections is an essential step.

Chris Comeaux 26:47

Yeah, it's so wonderful. I don't know if you're familiar, you probably know Dr. BJ Miller in Mettle Health. Um, I don't know if you know him. He's kind of the, I always joke, he's the sexiest man alive in palliative care. And so BJ's an incredible guy, very dynamic speaker. He became famous via TED Talk and he has a very unique innovation called Metal Health. It's not quite hospice, it's really kind of in that serious illness space, but much more holistic in nature. But their team uh all grew up in hospice and now they're part of this innovation. And as I was listening to them talk, I feel like they were helping me rediscover our community roots, especially as community-based nonprofit hospice and body care programs. Those roots are so unique and actually part of our superpower as an organization. And the other interesting thing, we had Judi Lund Person. I don't know if you know her more. She was a longtime regulatory person at our national organization. Everybody knows Judi Lund in this space. She was part of the original association that morphed into NHO, then later NHPCO. And I had Judi on a podcast right after she kind of retired. She's retiring by working still as a consultant. And I asked her the question, I'm like, hey, what do you think we could rediscover that's maybe sitting right there in front of us? And she said, what you just said, the volunteerism portion of our care, maybe we've kind of it's become a task and we've actually forgotten how amazing that part is and what we do. And then, and I'll say one more thing, and you might want to make a comment. Dr. Atul Gawande's

Chris Comeaux 28:19

book, Being Mortal, when he talked about like having a daycare next to a maybe senior facility. I was on site at Michigan and one of our TCN members in Grand Rapids, Michigan, and one of the senior living communities that founded them, I got to go visit it. And I was standing in the parking lot and I heard kids, and I turned around and I saw there was a daycare actually attached to this beautiful Catholic, um, basically senior living community.

And I'm like, oh my gosh, they're actually living this. So, I don't know if that provokes any thoughts on your part, because I think maybe there are some little elements of light out there and some things maybe we've forgotten.

Dr. Mark Stoltenberg 28:56
Yeah,

Preserve The Core While Scaling Access

Dr. Mark Stoltenberg 28:57
I think it's hitting on, and this is a challenge. So it's one of the core messages I would probably share today. So our founding, I've learned from the greats that have helped found it here in the US, but how I've seen palliative care be founded in other countries, it is this very important historical process and tension between two things. I think there is the initial spirit that is deeply committed to the values of what we do and who we are, and is very countercultural in many ways to some ways in the tradition and the practice of medicine is played out in parts of the world. So it starts with that seed and then almost everywhere um wants to move forward for very good reason, and it's important, to how do we now institutionalize and grow this so everybody has access to it. But there is a tension of how do you measure it, evaluate it, regulate it without losing the spirit of why it existed in the first place. And I don't think anyone has figured out that answer yet, but I think one part of it is recognizing there is something unique about palliative care where we don't just focus on an organ system, we don't just focus on one certain part of the healthcare system. We are bringing values to our healthcare system, especially for the most vulnerable, the frail, and those nearing the end of life. And so, I think recognizing that we have a unique call, that we can't lose connection to where we came from. So, I think palliative care, more than any other specialty, probably needs a pause every five or 10 years in whatever country you're talking about. Are we still holding true to these values? Are we doing it in a way that's measurable, high quality, and then we can make sure everyone has access? Absolutely. But I think a regular pause and reflection to keep those things in tension, I think is really, really important.

Chris Comeaux 30:36
I love that, Mark. I don't know if you uh you probably don't know this, but if you ever look at the logo of Teleios, um, again, I'm a bit of a history geek, but I'm also a business book geek. And so Jim Collins, who wrote the book Good to Great, everybody forgets his prior book was really his first kind of home run, which was called Built to Last. And he had a principle in that book that was preserve the core, stimulate progress. And he is so great about using like sticky metaphors. And he'd say great organizations are like this hurricane

with all this beautiful chain swirling about, but in the middle, like the eye of a hurricane, there's this somewhat unchangeable core. In other words, the more that you use that core, there's all this innovation that spins about, and even the core morphs over time, but it's not throwing the baby out with the bathwater, hence the term preserve the core, stimulate progress, which almost sounds like this real dichotomy, but yet it's this really interesting paradox. And so we took that. If you have a look at our Teleios logo, it's got this swirl in the middle. We're actually trying to connotate exactly that. And I've seen it my whole career because even the lady who started the hospice where I grew up in it Four Seasons, I had to interview with her. She was the matriarch, she wasn't on the board, but she had founded our hospice over soup and sandwiches in her living room. And she told me in the interview, she goes, we did not become Medicare certified till 1988. Now I'm 30 years old. I think I know everything. And I'm thinking, oh, you poor little hospice, you were so unsophisticated. You couldn't figure out how to comply with the conditions of participation. She said, No, no, young man. We saw this vision of what I would now say this incredible serious illness space. And while we saw the beauty of what the hospice benefit would do for the country, we were also concerned about fitting into that box and the needs that we would not meet. And like, oh my God, I'm like, I think I'm sitting here with the most brilliant person I've ever met before. And we would tell that story quite a bit in our culture to do exactly that. How do we keep preserving that core and keep stimulating progress and innovation? So, um I love that you brought me back to that. And there's no perfect formula there, right? There's always a tension between those two.

Dr. Mark Stoltenberg 32:51
Yeah, I think that's right. And I think um, for anyone in this space, especially those of us that are younger that weren't around when it was birthed here, I think remembering and hearing, and for me, a way of understanding how the people in the 80s must have felt is seeing what Dr. Thompson felt like 10 years ago in Belize or my colleagues in Jamaica or Trinidad and Domingo or in Chile.

Closing And Part Two Tease

Chris Comeaux 33:11
Yeah, that's exactly why I wanted to have you on a podcast because I feel like in some respects you're, whether you know it or not, you're kind of an interesting bridge of exactly that kind of a founder spirit, but also innovation into the future.

Jeff Haffner 33:22
Don't miss part two of this episode coming this Friday.