Podcast 347 Pettus Transcript

Karen Wyatt: Today. I am so honored and grateful to welcome my guest, Katherine Pettus. Katherine is the senior advocacy director for the International Association for Hospice and Palliative Care, the IAHPC. And in that role she represents the IAHPC at meetings of the United Nations organizations to advocate for improved availability and rational use of opioids for palliative care as a component of the right to health. And she plays other roles as well that we'll be talking about today. Katherine holds a PhD in political theory from Columbia University and a Master's degree in Health Law and Policy from UC San Diego. She also trained as a hospice volunteer in 2010. Katherine has an extensive list of publications and edited volumes, journals, and a blog. Some of her writing is collected in her self-published book *Global Palliative Care: Reports from the Peripheries*, which is fascinating. I just recently read it and I highly recommend it if you want to get a ground-level feel of what's happening in other countries in the world. So you can learn more about the IAHPC, and Katherine is featured there on the about page at hospicecare.com. So Katherine, thank you so very much for joining me from all the way around the world in Spain.

Katherine Pettus: Oh, it's a great honor to be here with you. Thank you.

Karen Wyatt: Well, we've been corresponding by email for a short while now and I read your book. And I'm just so interested and fascinated in looking at end of life issues with a more global lens and perspective because sometimes I think our vision may get a little too narrow and we focus in on even our personal experiences and then our own communities. But I think it's very important that we remember that the entire world is dealing with some of the very same issues we are in our own lives. So I want to thank you for bringing that perspective to us.

Katherine Pettus: Oh, you're welcome. I mean, it's the 100% mortality rate that we can't get away from. So that's why the whole world is dealing with it. But as you saw when you read my book, I mean in so many countries, especially the lower and really resource-strapped countries, it's very, very rough. It's very rough for people who don't have access to palliative care or pain medicine. 80% of the world has no access, at least to morphine or easily used opioids with correctly trained people. It's just not there. So you can imagine the kind of deaths, and not just deaths, but prolonged illness that people have.

Karen Wyatt: And that's something I really want to get into. But I wanted to start by just asking you a little bit more about your role with the IAHPC and what that consists of and then also how you were drawn to do this work.

Katherine Pettus: Well, at IAHPC my actual job title - it just got changed - is Senior Advocacy and Partnerships Director because advocacy lately has been getting a bit of a dirty word in the multilateral organizations - by multilateral, I mean the intergovernmental organizations in the UN, the organizations where I work - because it's often seen as being funded by the private sector or like lobbying. We're not allowed to

lobby. There’s a difference between advocacy and lobbying at the global level. And really what we do is we build partnerships with government representatives and delegates at meetings to increase the understanding of palliative care. Because as you probably know - I think the last article I saw about it - that 70% of Americans don't even know what palliative care is and many of the diplomats at the UN meetings where we do advocacy, even at the World Health Organization, the World Health Assembly, don't understand what palliative care is. There's a tremendous deficit of information. Some people unfortunately equate it with euthanasia or if they know something about it, they think it's only for cancer or they think it's only for end of life care. So there's a lot of what I do is starting from ground zero and educating policymakers about why palliative care is so important. Not only how it can benefit patients and families and communities, sort of what we call the micro level, but also how it can benefit health systems as a whole. And I'm not just talking about it saving costs, although that's something it does. The evidence shows now that early palliative care upstream - we call it palliative care provision - saves on downstream costs.

But we certainly don't want to present it as the cheap option or the alternative to good prevention and health promotion and treatment. It's not an alternative. It's part of a spectrum of primary health care and it should be included in universal health coverage, which is one of the goals of the 2030 Agenda for Sustainable Development. And though that's what's called the Sustainable Development Goals, which replaced the Millennium Development Goals (which all the UN member states, all 194 of them committed to). So in theory, all countries’ governments in the world committed to including palliative care in their health systems through universal health coverage. We are so far away from that. But the only way to start - I think it was Lao Tzu said that - the journey of 1000 miles begins with the first step. So you know, we begin one step at a time. If I were to be so pretentious as to call it a theory of change, which it’s not, with lots of boxes and arrows and things like that, I would say there's a moral imperative once you know something. Once you have a piece of information about the fact that much of the suffering that goes on in 80% of the world is actually preventable by introducing palliative care into primary health care at the community level. Once you know that, there's a moral obligation to start building it, even if you start small and start with the first steps, the seeds are all out there. I've been to some of the poorest countries in the world and there are palliative care services. They're usually provided by faith groups or charitable organizations, very small catchment areas and certainly don't meet the public health needs of the population. So my job, that's a long way to get around to answering your question, but is to take those small seeds of what has already begun, which Cicely Saunders planted in the mid-sixties with St. Christopher's Hospice that long ago, take those small seeds and say, look, it's being done, it's being done successfully on the ground with very few resources. Now, it's time to build on that and integrate it into your health system and we can help you do that. So that's the partnership piece. So we don't call out governments for not having included it, you know, or wagging our proverbial fingers and saying, you need to do this. It's saying, look, there is this way that you can alleviate the suffering of your people and by the way, it has all these other benefits.

Karen Wyatt: And one thing I really enjoyed reading about in your book is the fact that you, at times, make visits, you travel to some of these countries and some of the villages that have palliative care programs and make home visits with them, which I found just fascinating.

Katherine Pettus: It's my great joy to have been able to do that before Covid and hopefully I can do it again. Now that restrictions are starting to be eased. If I have to go to a country for a conference or a meeting to give a talk and those expenses are paid, then I go and do the visits with the home care teams so that I can have that experience. Because for me, doing advocacy the way I do it, you know, I have to put on my suit and my nice shoes and makeup and go out and be like a diplomat in the world. I can't do that unless I have what's called proximity to my patients. And I, as you said in your introduction, I was trained as a volunteer. But if I don't have that existential closeness and experience myself then and I don't know whereof I speak then my advocacy is not authentic.

Karen Wyatt: And I think storytelling is one of the greatest tools of advocacy and education both. And you can only gather those authentic stories by being there and witnessing it for yourself. And that makes your book very powerful as well.

Katherine Pettus: Oh thank you. Yeah. For most of our advocacy, what I prefer to do, rather than having me talk… In the beginning when I first started this in 2014, I did a lot of the talking because palliative care wasn't included in a lot of the multilateral documents and high level declarations. They would always stop at rehabilitations. So I'd have to get in there and advocate to include palliative care in these kinds of "agreed language," it's called, of the UN documents. But now that it's included, what I prefer to do is to have the providers themselves speak - as you said witness - because they're witnesses. And even better are the people who receive services, whether it's family members or patients, if they can do it by video. Now of course we have zoom everywhere and you can have videos of patients. And we just had what's called a side event at the Commission on Narcotic Drugs meeting in Vienna where I was to advocate for improved access to controlled medicines because those fall under the drug control treaties. And so we had a side event on access to medicines in the Caribbean. And they had a wonderful video of a patient talking about how important morphine was to her. And that storytelling and that kind of witness moves more hearts than me getting up there and talking policy and law, quite honestly.

Karen Wyatt: Mhm. Yes. That makes so much sense. And you alluded already to the situation around the world with morphine, which I found shocking. I kind of knew there were shortages. I thought they were perhaps manufacturing shortages in some parts of the world. But until I read your book, I didn't realize all of the factors involved in this unavailability and inaccessibility of effective pain management for patients. So tell us a little bit more about that. The global situation… you already said 80% of people don't have access to morphine, which is alarming and shocking.

Katherine Pettus: It is shocking. And when I first heard it, I was just floored. I went to a conference in Fresno on Global Palliative Care because that's when I was training as a volunteer. And there was a conference on International Palliative Care and that's where I first met my two mentors, Dr. Ann Merriman and Raja Gopal from India. And Dr. Merriman said that in most countries in Africa, the strongest pain relief that's available is paracetamol for gunshot wounds, for cancer, for labor, for anything. And I was just so shocked. And that's when I decided I needed to get involved in this. But it has to do with the fact that the drug control treaties, as they're called… the UN conventions such as the Single Convention on Narcotic Drugs was drafted and ratified and approved, you could say, in the mid 20th century. So 1961 was when it was finalized, but its antecedents and its roots went well before that and came from the Opium Wars and the British Empire trading opium as a commodity. As you probably know, opium has been a medicine for thousands of years and has been a perfectly wonderful medicine for thousands of years. But then once it became a commodity and the word "drug" entered the language, which it never had before, then it came under UN control. And as I said, that was in the mid-60s. But if you think about it, the clinical disciplines of palliative medicine and addiction medicine didn't develop until the very late 20th century. Even though Cicely Saunders had her hospice in the mid-60s, the actual disciplines themselves didn't develop really until the end of the 20th century or the early 21st century. So there's this lag between law and clinical practice. And so the wealthier countries were able to integrate palliative medicine into their health systems in a much more productive way for patients with palliative care needs. Even though there are still big gaps in countries like Switzerland and France. You know, you'll have clinics in the capital cities, but get out to the rural areas and it's very challenging even in a place like Switzerland. But still you have the wealthier countries with good access to medicines, more or less, and clean trained clinicians. But many countries are still laboring under the laws and regulations and mindset - which is the really challenging thing about opioids - that came from these mid 20th century international instruments, which called addiction an "evil." They're the only UN treaties or human rights conventions… there's no human rights conventions that - even the nuclear arms treaties don't - call nuclear weapons an "evil." But the Single Convention on Narcotic Drugs says that it was written to combat this "evil of addiction" even though it's supposed to make sure that medicines are available for scientific purposes. Well, the damage was done by the time that word evil was out the door. And we're laboring under a similar chill now with the US and North American opioid crisis, which has brought this fear of addiction back in and has a terribly chilling effect on our advocacy. Because countries are looking at the US and Canada and Australia and the other places where this is an issue and saying well, we don't want to have an overdose crisis like this so we cannot increase access to opioids. But the thing is, it's got nothing to do with the opioids themselves. It has to do with the training of professionals and the regulatory framework within which they are made available, which is where the US really didn't do a great job. As the Stanford Lancet Opioid Commission report, which was published in February, talked about the whole North American opioid crisis and the causes of that and laying the blame at the feet of opioids, is just looking in the wrong direction. It's the system and it's the fact that laws and regulations need to catch up with clinical practice and evidence. So that's what we're trying to do is close that historical gap.

Karen Wyatt: And I know I dealt with many hospice patients and their family members who were very frightened of the use of morphine at the end of life. And even family members who said, is my father addicted to morphine now, is he an opioid addict? Because you're treating him with this. And so we have a long way to go here in the US to educate people. But it sounds like that's a global issue that we need to deal with because morphine is still the gold standard in terms of pain relief, you know?

Katherine Pettus: Yeah, there was a physician, his name is escaping me now, of course, in the 19th century who called it "God's gift to medicine," a pioneer, a medical pioneer. Yeah, I mean it is. And once you've seen it, or you've experienced it yourself - and I certainly have. I was in the hospital with a very badly broken arm for three days while the fracture was set in 2010 during the Haitian earthquake. And I was lying in my hospital bed with a morphine pump and able to get as much as I needed for pain when I needed it, watching what was happening in Haiti and people getting operated on without any anesthetic or pain relief and thinking, God I am so fortunate. And that again reinforced my desire to make the kind of benefits that we have available to others. And I have to add as a footnote that when I was discharged from hospital, I was not an addict in any – you know, I had some painkillers for a few days and it was nasty and it was rough - but I certainly wasn't addicted when I came out of hospital having had the morphine I needed for a broken arm. And there's evidence from some of the poorest settings in the world that use oral morphine like Hospice Africa Uganda and in Southern India and Kerala and Rwanda where they make up the morphine themselves. And you read about that in the book, they don't have diversion and misuse because their folks are properly trained. Plus morphine is not attractive to profiteers or to traffickers. It's not a traffickable drug when it's made up into pain relief for oral morphine.

Karen Wyatt: And I wanted to ask you to talk a little bit more about those countries that are doing well because I was really interested to learn that it's… they can obtain morphine as a powder that can be reconstituted, which I hadn't even been aware of before.

Katherine Pettus: Well Dr. Merriman is the pioneer of that in Africa. And she also did that and she learned to do that actually in Singapore with Dr. Cynthia Goh who recently just passed away. But that was in the eighties. So we're still talking 20 years after the Commission on Narcotic Drugs was ratified. But she was telling me about how they did that in Singapore because they had made what was called the Brompton cocktail. That's what Dr. Cicely used to use at St. Christopher's Hospital. But they used to mix that with alcohol and cocaine and all kinds of things to make the patients comfortable because that's what they had in the sixties. And so when Dr. Merriman went to Singapore and she started collaborating with Dr. Goh, visiting patients at home who were dying in terrible pain, they went to the pharmacists and they said, well how can we make it without all the stuff that's in the Brompton cocktail? So they came up with this formulary which is the same formulary they're using today at Hospice Africa Uganda. They use it in Kenya, they use it in Kerala. And they were using recycled water bottles with vegetable dye to show the different strengths, whether it was 5 mg, 10 or 15. So the patients could tell the

difference when they were being dehydrated for the different strengths, and it's very simple. It's not something that, as I said, traffickers are interested in and it's very inexpensive. So the government pays for it in Uganda, they subsidize it, and that's the solution literally and metaphorically, yeah.

Karen Wyatt: It sounds like it's very sustainable because it's easy to transport and store. And in rural areas where people have to travel from village to village. It's something they can bring with them and administer and they don't need to have syringes, and tubing, and vials of things.

Katherine Pettus: Exactly, yes. Some countries only - and I'm saying countries very loosely but it may be just one clinic in one capital city - the only morphine they might have is injectable for instance. And so patients needing pain relief can only get it by going to the hospital, which may be hours away on expensive and uncomfortable public transport - which if you're a terminal patient, you don't want to do. Anyway, so that solution, as you said, is sustainable and it's portable. And in Uganda they pioneered this model of nurses being able to prescribe it because the doctor to patient ratio in most African countries is so incredibly low. I mean it's 1[doctor] to, I don't know, 7000 people. So you can't have doctors prescribing, and in many countries only a doctor can prescribe controlled medicines and only an oncologist might be able to prescribe controlled medicines. So if you can have trained nurses prescribe, you know, you've got the model. So that's what Dr. M has done to her incredible credit.

Karen Wyatt: Yeah, I found that to be such amazing forward thinking of how to address multiple issues for one shortage of providers. And I would love to see that kind of thinking take place here in the US because we have some of the same issues that have to be addressed. But in terms of some of these poorer countries, where do we need to begin? Is it a matter of education or do we… It sounds like it's a multifactorial problem and we may have to address it from many directions.

Katherine Pettus: Yeah. But what I love about palliative care and as I said, I trained as a hospice volunteer and I was fortunate enough to work and… to train *and* work because I worked on the interdisciplinary teams at San Diego Hospice when it existed - it's not there anymore. But what I loved about it is how it's what I call "joined-up thinking" or you know, another way of it is "sideways thinking." It's totally thinking out of the box and thinking through chaos. Because as you know, having done it many times, end-of-life care and death and dying are, by definition, chaotic kinds of situations. They're not manageable in any kind of way that you can impose through a model one size fits all. And what's so amazing and versatile about palliative care is the way it's like jazz, that they manage that situation and they riff off each other, a good team. And it's deeply democratic, the best-practice palliative care. I, as a volunteer, was sitting around the same table with the doctors and the nurses and the social workers and the spiritual care providers. And I was treated as an equal. It's deeply democratic and it's based on what, in political theory, we called "speech acts." So it's dialogical, and that's how you get to new forms of knowledge. And you think out of the box and the way that Anne [Merriman] did for devising that oral morphine and nurse prescribing model. It's natural for palliative

care to be able to manage that kind of complex situation. And you can do it. What I'm interested in is how it translates from the bedside, so the micro level, so to speak, to the macro level, to the society into the health system. And I think palliative care has a huge amount to teach at the macro level about how to solve complex problems.

Karen Wyatt: Mm hmm. So true. I agree with that completely. And that was one of my favorite aspects of being involved in hospice care. It was being able to be creative in the moment and stepping into a situation. And honestly, every patient was different. Every family was different. Every crisis we faced was different in its own way. And it required us to think in the moment to come up with some sort of creative solution to whatever problem we were facing at that moment. And you're so right in saying that as a team is absolutely the best way to come up with a solution. Because the synergy is incredible between people with different perspectives and different experiences all coming together. And it's far more effective than any one person trying to step into a situation and think of a solution, to have this team-oriented approach.

Katherine Pettus: Yeah because you go in with a "don't know mind." You just do. And together you somehow steer your way through. And it's extraordinary, with grace.

Karen Wyatt: Yes. And I think there's something about the interdisciplinary team meetings when everyone comes together and we actually share our stories of, what problem did we face, and how did we solve it? We reinforce with one another this value of being creative in the moment, and we empower each other to keep thinking of these new ideas outside the box. And we don't get stuck in old protocols or standardized ways of approaching problems.

Katherine Pettus: Yeah the UN needs this so badly. That's just what I see. I think palliative care has so much to teach the world. And that's one reason I look forward to writing another book about it.

Karen Wyatt: Oh and I'm glad - I look forward to reading more of your writing about that. Well I wanted to also discuss with you the issue of family caregivers because you brought that up in your book. And it's something that I've been looking at and interviewing people about this year because I feel like it's a crisis situation for sure here in the US. But it sounds like it is everywhere. And I wanted to get your perspective on that.

Katherine Pettus: Well, we had, I think I mentioned to you, we also had Jessica Zitter show the film and talk about her film *Caregiver, A Love Story* for our membership. And that was terribly helpful because I've seen the caregiver issue in these very resource-strapped countries. Often of course it's women, but it's also men. It's often older people, older women who have absolutely no compensation, no income, no resources, no training, nothing to help them. Or it's girls who have to drop out of school in order to do that. So you've got three or four people who are forfeiting income as well as education, often to take care of a seriously ill family member, or you have no one at all. And palliative care, especially when it's provided at the community level, whether it's through

Compassionate Communities - and that's a whole other conversation which I can recommend you to some people to talk to - that's the community way of providing care. Or whether it's through a palliative care team that can just come and visit several times a week to the home to assist and train the caregivers. But as Dr. Zitter said, it's like you're expecting people to perform high level nursing skills that have absolutely no training at all. And what governments are doing is, they're outsourcing tremendous amounts of things that they should be doing through the public system onto the shoulders of people who already have tremendous burdens, whether it's work, health, or other things. And then all of a sudden they have to become caregivers, and they lose their savings, they lose their jobs. And there are very few countries in the world that provide support to caregivers, and one of them is Costa Rica. So we have an advocacy focal point in Costa Rica who is a young woman who took care of her father. She is a physiotherapist, a palliative care physiotherapist. But she was able to take time off work and school and was given a stipend by her government to take care of her dad at home. And she was given support by the palliative care team, and all this was publicly subsidized. And that's the model that needs to be adopted. Very, very few countries in the world do that. Costa Rica does that. One reason they're able to do that is they don't have a standing army. So they don't fund the military so they can fund palliative care. What a concept, right?

Karen Wyatt: Yeah, exactly. They have the funds available to help support these forward thinking ideas. And I guess what surprised me somehow… I mean, this was like stereotypical thinking. I just assumed that in many other countries there were more extended families and more support from other family members for the nuclear family - more so than we have here in the US. But I realized still, even if there is an extended family, it's still a burden because many of those extended family members are working outside the home. They may live together, but they're working just to support the family. They're not available to caregivers.

Katherine Pettus: And also it's becoming a bit of a myth of the extended family with women who don't work being available to take care of grandma or whatever because there's so much outsourcing of labor and globalization and migration. I mean think about the Philippines and the amount of women and men who leave the Philippines to become nurses or nannies or care providers to people in many other countries. Well, guess what happens to their older people? There's nobody home because the younger people are all leaving, whether it's for the cities in the same country or overseas. So you don't have the same amount of people giving support within the home as it used to be the case.

Karen Wyatt: Yeah. So that definitely makes sense to me that it is a global problem. So we shouldn't just be looking at that right here in our own neighborhood but thinking larger as an issue that has to be addressed. And you wrote about something you called the health poverty trap, and I wanted you to talk about that.

Katherine Pettus: Well that feeds into the caregiver issue because when you have someone who's seriously ill and you need someone to look after them… If you don't have palliative care for those people that's provided in the home, and the girls have to drop out of school, which is often the case… Or the income earner is either the patient and/or the

caregiver who has to leave the workforce, whether it's the formal workforce or the informal workforce to take care of the person, then you have tremendous… Already you have a deficit in terms of income. But then it gets worse because in many countries where there's no good palliative care at the local level, you have the medicalized Western model where people will go and look for a cure at any cost. You know, all of a sudden they're told they have cancer, and they're living on the edge anyway in terms of their income, like so many people even in the States now, or just paycheck-to-paycheck. And so they go hunting the holy grail of a cure, and they're sold all these medicines or they're sold all these treatments which puts them into debt because nobody is willing to tell them the truth - that is, that their illness is life threatening, possibly life ending, and that there is no real cure for it. Yes, you can do this many rounds of chemo, which will cost this much. But you know, there's maybe a 14% chance of survival or whatever. So they go into tremendous poverty, they sell land, they sell jewelry if they have it, they sell whatever resources that they have to pay for these phantasmagoric magical cures, which don't happen. And there's no palliative care around to help them when things get rough. And that sets families back generations, especially when education is compromised. It sets them back generations.

Karen Wyatt: Mm hmm. So in a way we have introduced some of the Western model of approaching serious illness and it's not helpful to those people. Just as it's not helpful here to people who can't afford the care or who don't have health insurance and may be going into bankruptcy here trying to get treatment which they haven't even been informed might be futile treatment that's not going to make a difference for them.

Katherine Pettus: It's more than not helpful. It's actively harmful. So it counteracts that ethical principle of beneficence. It's maleficent and it's a medicalized model of death that in many ways is more virulent in what are lower and middle income countries that want to be westernized. For instance, in India, my friend Dr. Raja Gopal - who's considered the Father of Palliative Care in India - he talks about how the poor die without medicine and without care often, if they don't have access to palliative care. And then the rich die in the intensive care wards or tied up to tubes and without any kind of dignity or pain management at all because everyone's trying to cure them and they can't see their families. They don't have any kind of dignity in their exits at all. So it's bad for the rich as well as the poor. And in many poor countries, the elites, including the government's civil servants, they're flown out at the government's expense to other countries to get treatment. So there's a huge expense. And then they end up dying either in those countries or not getting the cure they need, coming back, and then they're bankrupt because they've been seeking this medicalized cure.

Karen Wyatt: So, I can see such an important role for palliative care to play for one thing, because palliative care providers tend to be truth-tellers who have the skills to have an honest discussion and talk to people about what is realistic now in terms of the kind of treatment that you receive. And it's sad that that's missing in other aspects of medicine, but it's crucial in terms of helping guide people to make the right decisions or the best decisions for them.

Katherine Pettus: Yeah, truth-telling is one of the core pieces of that. Again, going back to that biological model of palliative care. As you said in your introduction to me, my degree is in political theory. And so I used to study citizenship and power and democracy and things like that. And one of the things I noticed when I was being a hospice volunteer and a member of a multidisciplinary team was what are called the virtues of citizenship, the classical virtues of citizenship: our courage, truth-telling, friendship, and magnanimity, which is greatness of soul. That's what the Greeks thought was the mark of Aristotle, basically a good citizenship. And that's also the mark of a good palliative care team. They reflect those same virtues of citizenship. And I see palliative care as a way to really strengthen and rebuild, again in a theoretical word, the polity; the country, whether it's the community or the country or the the district or whatever that those virtues of palliative care can translate from the micro level to the macro level and really strengthen communities in a way that they might not have thought possible.

Karen Wyatt: Hmm, I can see that. And I also believe that expanding palliative care would help with some of the burnout that medical providers are experiencing because if you spend your day dispensing treatments that in your own depths you realize are not likely to work or to help the patient that you're treating, but you don't know what else to offer them. You have no other tools. You have nothing else. You're doing it because you want to do something for them. But if deep down inside you know, this is probably not going to help you, that is incredibly destructive, I think. And I think the palliative care mindset would help all providers, even if they themselves don't offer the palliative care. But if they refer someone to a palliative care team, there's a way to be helpful that is going to make a difference for the patients.

Katherine Pettus: Oh, absolutely. And that's called moral harm. I think it's called moral damage, what you're talking about. And there's quite a lot of good research about how palliative care and the attitude of compassion in providers immunizes them, so to speak, against burnout. There's a wonderful book called *Compassionomics* that's come out of Harvard and a whole study of the benefits of compassion. It's not just being nice and singing kumbaya and feeling good together. It is some really hard science now around compassion that can be again extended from the bedside to the cosmos.

Karen Wyatt: Mhm. Yes. That's beautiful, and I'm interested in that book. I'll have to take a look at that. Well, one thing you also wrote about is that we need a Palliative Care Peace Corps, and I really like that idea. So, would you talk about that?

Katherine Pettus: Well, that's a fantasy. I can't remember when that happened, when I thought about that. But contemplating the scale of the problem again - I guess it's sort of Kennedy-esque - why not think about doing that because, in a way, many of my colleagues who are global - I don't want to say they're global palliative care providers - but what they are is they're trainers. Their generosity - that's that magnanimity, greatness of soul - the magnanimity of so many of the providers I know who go around the world to teach. They volunteer their time, whether they go to Gaza or they go to South Africa. They go everywhere to teach and try to plant these seeds of how to start a small team, and then they learn from the colleagues on the ground in those countries. It's not like bringing

expertise and filling up an empty cup. We all learned; it's capacity bridging rather than capacity building. So they in themselves are doing the best they can with very limited resources because they also have professional jobs and they have families and they, you know, they can't just all pick up and go and be palliative care nomads, so to speak. But why not do a "Palliative Care Peace Corps" and have people be able to go and bring the kind of knowledge and take the kind of wisdom that's available in so many traditional societies and with traditional healers. Again, going back to opium and morphine, it's a traditional medicine, and there's no reason why it can't be cultivated and grown. Even if it's allowed under the conventions that it can be cultivated up to a certain amount and grown and processed. It's just that the modern pharmaceutical industry and the modern medicalized healthcare systems have disempowered those kinds of local indigenous initiatives, and it's time to bring all this back. And there's no reason why a Palliative Care Peace Corps couldn't be part of that.

Karen Wyatt: I like that idea - that could work, it could! I like the idea of attracting young people to serve, perhaps in the Palliative Care Peace Corps, either locally or abroad, wherever there was a need because of how impactful exposure to palliative care and to end-of-life situations is for young people. I think it's really important knowledge that they could gain that would change their lives. Because that's something else you wrote: "Palliative care transforms everyone who participates in it." And I love that. I think that's really beautiful. And imagine if we could expose younger people in our society to palliative care and what a difference it would make for the rest of their lives.

Katherine Pettus: Well they're doing it in Kerala in South India, and they're doing it in Colombia. Because I'm in Spain, I went to the PhD dissertation defense of a colleague in Seville who was doing her PhD on compassionate communities around the world, and they have compassionate universities. They have compassionate schools, and they start working with grade schools to teach them about palliative care and how to take care of people in their community. So the seeds are there, it just needs to be broadcast and expanded. And I think with this era of zoom and the communications we have now and the really, really smart young people that we have now, there's no reason why they can't do it.

Karen Wyatt: Yes. We just need more of that out-of-the-box thinking. And then people with a will to do it, to create it wherever they are with whatever means. They have to start something like this in their community in colleges. And I love the idea of, all the way down to grade school, teaching children how to be helpful and how to help care for someone else.

Katherine Pettus: I'll send you some of the links for the show notes.

Karen Wyatt: Yes, I'd love that. Well, I'm wondering… If listeners are feeling interested, how can they get involved in assisting on the global level? What are things that the rest of us could do to help support the kind of work you're doing?

Katherine Pettus: Well, the best thing they can do is to get informed: it's knowledge. That's how I started. So you can start reading about it. You can look at our website, http://hospicecare.com. Subscribe to our newsletter. That's free. Just sign up to be on our mailing list because every month we produce a newsletter that talks about the global palliative care movement, and I have a monthly talk about advocacy. Some of it gets a bit technical - my stuff. But you'll get a real sense of what's going on in the world. Make a donation to our work because, to avoid conflicts of interest, we are dependent on donations and memberships. We have a global membership. We have people in more than 100 countries who are professionals. By professionals I mean, they can be social workers, spiritual care providers, doctors, nurses, all the elements of a multidisciplinary team, as well as fellow travelers, people who just want to support us, educators… So it's basically supporting the growth of this movement, which is… It is a global palliative care movement. It's very cosmopolitan in the sense that it's not confined to one country, one government. It's global civil society at its best. And it's an extraordinary amount of growth and excitement and hope for the future in this movement. That's what keeps me getting out of bed every day, even in these terrible times.

Karen Wyatt: Yes, yes, I can see that. And I was curious to know if Covid… You mentioned that you weren't able to make some of the visits that you had made in the past during times of Covid. Have you seen the global impact of Covid as making any difference in palliative care one way or another?

Katherine Pettus: It cuts both ways. We did a survey of our global membership to find out how it was affecting them. And it affected many very negatively of course, because their services were often shut down and they were reassigned to the quote unquote "front lines" of giving injections, vaccines, giving tests, doing all the immediate infection kind of prevention and control. That was the first wave. Many patients with palliative care needs were not able to access services. But then on the other hand, there was a much greater awareness of the need for palliative care and the need for the skills of the very few palliative care professionals that are working in many countries. And so there was a call for that, and it's evolutionary - it's the only way I can think of what we're doing. It's so slow and that can be really… that creates real tension between the terrible suffering and needs of patients all over the world. We know there's terrible health-related suffering all over the world and the slowness of the paradigm change, which is evolutionary. So that tension is a hard place to be in. But you know, those of us who have dealt with death and dying on a daily basis… It's what the zen teachers called holding your seat in that.

So it cuts both ways. It's raised awareness of the need to be more death-literate, and you've done a lot of great shows on that. And it has also put more patients in the situation of not getting the services they need. There's terrific awareness. Now, the need for medicines and pharmaceutical supply chains… And the World Health Organization is putting skills and technical assistance into local manufacturing, finally. So we're not all dependent on a few countries for pharmaceutical raw materials. And poppy is a great example of something that can be locally grown and manufactured.

Karen Wyatt: Yeah, it's interesting. I feel that Covid exposed a lot of our weaknesses, but it made them visible to all of us. And so those of us who may have been a little bit oblivious about what was happening, we're seeing a lot more clearly the problems we have and the issues that have to be addressed. And they're huge and overwhelming in so many ways, the disparities and inequities in healthcare that exist all around the world for the poor and those who are oppressed. But we have to see the problems before we can begin to address them. So it's now visible. We can now all see it and take a look at it. And hopefully we feel the urgency of it and the motivation to start working toward greater health equity and less suffering in the world.

Katherine Pettus: Well and knowing that you can do it, as we said earlier, in a team makes all the difference. You know, we don't have the weight of the world on our shoulders. If you're a person of faith, you know that you have that other dimension at your back as well as your co-workers, and we can do it. So there is a moral imperative. Once you know, as you said, then you have a choice. You can bury your head in the sand and just sort of pretend none of it happened and you can't deal with it. Or you get to work, but you get to work with a team and with that mutual aid sense of, yeah, together we can do this. And if Ukraine is teaching us anything, it’s extraordinary how people are doing that kind of mutual aid and volunteering and dropping everything to help each other, not just within Ukraine, but within all the countries around it. Extraordinary.

Karen Wyatt: Yes, yes. We have this living example before us every day that we can do amazing things when we're pushed to it and when we come together and work side by side.

Katherine Pettus: Yep, solidarity.

Karen Wyatt: Yes. I wanted to mention your book again, *Global Palliative Care: Reports from the Peripheries* because I really enjoyed it. It was very illuminating and educational for me to read. And where can listeners get a hold of the book?

Katherine Pettus: Dear old Amazon! I wrote it when we were on lockdown in Spain because, during the first wave, none of us knew if we'd come out of it alive. And I just thought, well, I can't do anything else. So I might as well… I mean, I had my job of course, but when you can't leave and you can't even go for a walk around the block without getting told to go home, I had to think of something to do. So I put all my blogs together and just published it with the help of a few technical people. So I made it very inexpensive so that colleagues in low income countries could buy it and download it. Best to download it from Kindle because the photographs are in color. If you download it, the actual paperback book itself, they’re in black and white. But any royalties go to Hospice Africa Uganda to pay for nurse training to prescribe morphine because it actually only costs - and I'm saying only from a high income country point of view - 3000 or so dollars to train a nurse at Hospice Africa Uganda, if you can imagine that. So she or he - there are men who are palliative care nurses or medical officers - can then go out and prescribe morphine. And they're on a shoestring, terrible shoestring budget there. So I

just wanted to give whatever money from the book came in to Hospice Africa Uganda Institute for Palliative Care.

Karen Wyatt: I'll leave a link to it then. I got the Kindle book and it's nice to have those color photographs of your travels and some of the villages that you visited.

Katherine Pettus: Well thank you so much.

Karen Wyatt: Yeah. And thank you for talking with me today from so far away. And I'm really… I'm just so grateful knowing that you're there doing the work that you're doing because I think it's crucial. We need your advocacy and the education that you're doing and the partnerships you're forming. And I'm so happy that you're willing and able to do that work, and I'm hoping all the rest of us can somehow be on your team and be part of that support.

Katherine Pettus: Oh, you are already. It's all a team effort. I couldn't do it by myself. We're only six of us on staff at IAHPC. We're tiny but mighty. An Australian colleague said we punch above our weight. So yeah, we do. But it's great.

Karen Wyatt: Yes, wonderful work. And we need much more of it. But it's so nice to know someone's there planting seeds every day, and that's how we all begin. So you've inspired me to want to become more globally aware and stay aware and figure out other ways that I can be helpful also.

Katherine Pettus: Well, you're doing terrific work. So yeah, we all help each other. We're very blessed.

Karen Wyatt: Yeah. It's really a privilege to be able to do the work and to have these experiences and to have this knowledge and to meet all the people in this field. It's really wonderful.

Katherine Pettus: Yeah.

Karen Wyatt: Well, thank you again, Katharine. And many blessings to you and safe travels to you in the future, too.

Katherine Pettus: It's my privilege. Thank you, Karen.

Karen Wyatt: Thank you.