A Conversation About… Supporting Families and Patients in Palliative Care

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Kate Cogan (00:19):

Welcome to this episode of a conversation about treatment, care and support for people with a terminal illness along with their families and loved ones. My name is Kate Cogan. I'm joined here today by Emeritus Professor of Psychiatry, Dr. Sid Bloch, and Dr. Adrian Dabscheck, former GP and palliative medicine consultant and senior lecturer. Welcome Adrian.

Adrian Dabscheck (00:44):

Thank you.

Kate Cogan (00:45):

Great to have you here and welcome to you too, Sid.

Sid Bloch (00:48):

Thank you.

Kate Cogan (00:48):

I've invited Adrian and Sid to the conversation as they both have many years of experience in the field. Sid's expertise as in research with his main interest being in psycho-oncology, namely family grief, enabling the establishment of a counselling programme, focusing on supporting the patient and their family together as they navigate the journey of dying and grief. Adrian spent 31 years as a GP, then retrained in palliative medicine, working at Peter Mac and RCH and Western Health. His focus now is on teaching death and dying to second year medical students at Melbourne Uni. I'm a senior credentialed mental health nurse and a clinical family therapist and have worked in psychiatry across the lifespan for many decades. I work as a clinician, counselling and supporting families, significant others, and the dying

as they travel their journey of grief to an unknown destination. What I have learned over the decades in my clinical work is that dying and grief is a very individual experience.

(01:56):

It is a journey to an unknown destination. We cannot control it. We can try, but it will take its course. It has no timeline and it is the mind and body teaching us to learn to manage life differently. It is like a tool that allows us to gradually adjust to our loss and find a way of going on our way with our life without those or that which we have lost. By leaning into grief, you are afforded an opportunity to better connect and understand the values that are dear to you. It is both a space of enormous discomfort and of enlightenment. Our body can feel like it is in a state of shock, feeling confused, overwhelmed, isolated, changes in sleeping pattern, the way we eat, feeling empty, depressed, anxious and guilt. It is fearful and we do not want to experience this state of shock again. Our grief can impact those around us like a stone cast into water creates a ripple effect. The opportunity of connecting with our values helps us further develop our strength, the resilience for life. There is no correct way to grieve. To kickstart, Adrian, can I ask you to provide Sid and me and our listeners an overview of the overarching principles which apply to best practise in the provision of treatment, care and support of people living with the terminal illness?

Adrian Dabscheck (03:21):

Yes. The WHO has a number of definitions. I'll read out the previous definition, which I think was defined in 2014. Palliative care provides relief from pain and other distressing symptoms, affirms life and regards dying as a normal process, intends neither to hasten or postpone death, integrates the psychological and spiritual aspects of patient care, offers a support system to help patients live as actively as possible until death, offers a support system to help family cope with the patient's illness and in their own bereavement. We use a team approach to address the needs of patients and I really should emphasise team to address the needs of patients and their families, including bereavement and counselling. If indicated, palliative care aims to enhance the quality of life and may also positively influence the course of the illness. It is applicable early in the course of illness in conjunction with other therapies which are intended to prolong life such as chemotherapy, radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Kate Cogan (04:43):

I heard you say it is not to hasten death. Does that create challenges with some families?

Adrian Dabscheck (04:49):

There's a lot of misinformation in the community that once we introduce certain medications such as opioids, there's a general consensus out there that we're hastening death and judiciously use, there's no evidence that opioids hasten death, nor that anything else we do hastens death, but our aim is always the relief of distress and suffering.

Kate Cogan (05:13):

And you've worked as a GP and now you're a palliative care consultant. Do you see overlap? Do you see the challenges of GP's being maybe the first step?

Adrian Dabscheck (05:25):

Well, we're very fortunate in Victoria that the communities have divided up and we have very active community palliative care services. They work in conjunction usually with the major hospitals and rural hospitals and general practitioners. We encourage to be part of the team and if we can involve gps, they're an essential part of the team and they know the family. However, it can be difficult because it's a very time consuming process being involved in palliative care and unfortunately the gps, are busy, but it's a challenge to involve gps. But when they are involved it's usually very gratifying for them, their family and the services as well.

Kate Cogan (06:12):

Can you talk a little bit about the team approach? I know the team are there to support the family and the person dying, but sometimes the team needs care as well.

Adrian Dabscheck (06:23):

Yes. Well, the team, as you say, is there to support the patient and the family and by team we mean a number of different practitioners, palliative care nurses, essential and the core of palliative medicine teams, a consultant, a doctor like myself, we do the prescribing, but the nurses do so much of the caring. We can enlist allied health and physiotherapy. Physical assistance can be, physical aids can be very helpful. People often need a hospital bed in their home if they want to die at home. But putting that aside, it is challenging work and we need the team to support each other emotionally. And I don't think you could practise this sort of hands-on end of life medicine as a solo practitioner.

Kate Cogan (07:13):

Yeah, it'd be very difficult. I think having worked in that field myself, I have valued the opportunities for support as part of a team. Sid, have you got anything you wanted to offer there?

Sid Bloch (07:25):

Well, certainly in psychiatry and also other mental health professions, working as a group of, if you like, experts in a way in different spheres, all with a common aim of caring for a patient who is vulnerable and prone to the stress and other things that you were mentioning at the beginning. When Adrian first got into palliative care, I got the impression that he was working solo because palliative care wasn't really doing that collective approach that you've mentioned.

(08:00):

And I thought, oh my goodness, how can you cope with all that? And I still feel something like that, but I can see that if you're working with colleagues, lots of mutual support and a provision of other ideas about how to approach the situation, because, it's as we'll come to I think shortly, it's not just the patient who is ending his life or her life, but also the family and close friends who are playing a very prominent role. And of course will also be affected by the situation and eventually by the loss. I dunno if it's relevant, but being a GP for all those years may or may not have put you in the picture of ultimately working in the palliative care area. Psychiatrists don't really get that caught up. And this is for mental health professionals. So there is a question that arises as to who is best situated and I think it's bluntly clear that it is a team, but I still would raise the question with Adrian and yourself, Kate, as to what do you mean by a team? Do you then, be sure to have the fully pledged palliative care physician, occupational therapist, or a psychologist and the like?

Adrian Dabscheck (09:19):

Well, the team will vary depending on circumstances. I spent some time working at the children's hospital and then occasionally a child and family would prefer to go home to die and often that was in a rural situation and they're not very well resourced. So the team can comprise the local policemen, comprised of various people in the community who are willing to assist and help as well as a local palliative care, usually a nurse. And that's where the country gps tend to be a different breed than city gps and can be very, very helpful. Working as a consultant in a big city hospital, the team could compose social workers, psychologists, various allied health, especially occupational therapists working in the community. You would have access to bereavement and grief services as well as very active nurses and physiotherapy and allied health would be available. But you would always need a doctor who can prescribe, assess symptoms, distress, and be an essential part of the team. So the team can vary according to the circumstances. And a lot of deaths take place in aged care facilities. And there it's the facility of the aged care home as well as a visiting doctor usually. And if it's a bit complicated, they'll get community palliative care services involved with what they can bring.

Kate Cogan (10:57):

I've had a wonderful experience of being part of a palliative care team in an aged care facility where the couple had been my patient for a long time, referred via the GP under the Mental health nurse incentive programme when that was out around 2010. And that family went into aged care. The wife had Parkinson's and I continued to see her in aged care and then she started to deteriorate and we got in palliative care, we had the aged care facility. I was there, her daughter was overseas in America, so we were in close contact with her until she could get out here. And it was an absolute privilege to be part of that process and allow her to die as peacefully and as comfortably as she could. And I was sort of a bit of an outsider with that team. I wasn't necessarily part of the palliative team, but I was invited in and got to work with them.

Adrian Dabscheck (11:48):

I think you were part of the team.

Kate Cogan (11:49):

I think I was.

Adrian Dabscheck (11:50):

You were providing care.

Kate Cogan (11:53):

Yeah. I just find it is such a privilege to be part of that process. We can only die once. We don't get to do it again. Families don't get to do it again. And I think the team approach to palliative care allows families to do that as best they can.

Sid Bloch (12:08):

Now I was also remembering when Kate contacted me, I couldn't remember who she was and then I had to put two and two together and work out. Oh yes, she was one of the 15 social workers, nurses.

Kate Cogan (12:22):

I'm a nurse, mental health nurse, general nurse then.

Sid Bloch (12:25):

But there were non doctors as it were, who were felt to be most suited. And just putting aside the question of pain controller and other medical issues, to do, if you like the therapy side of things, lets call it psychotherapy, but I'd rather replace that with counselling. So I come to the point about who is most suitable. We've worked that one out to a degree and how training should occur. And I always find that a tricky one. Do you bring your native skills like a doctor would? Well maybe still needs some training and pain control because it's quite a complicated and challenging thing. And social workers sensibly work with groups like families and so on. So I did throw out the question many years ago about how we should compose the training programme. And I'd just like to mention that briefly here because you listening out there may be interested or may actually be doing this. And the question is, do you feel comfortable doing it? Would you feel comfortable choosing that sort of work either full-time or part of your time and being more in academic sphere and clinical sphere? I became convinced that we had to sort out something along those lines of training.

(13:57):

How best to accomplish it. When do people become absolutely confident? They don't become absolutely confident obviously, but when they feel confident, and what sort of expertise or what sort of qualities, what sort of attributes.

Kate Cogan (14:13):

Adrian, you are in training, the gps?

Adrian Dabscheck (14:16):

Well actually I teach medical students along the lines of what Sidney's just touched on, you mentioned it's a privilege to be involved with patients and families towards the end of life. I think we have to teach the students, the young doctors, they have to earn the trust. So a major component of what we teach is how we develop a relationship. Just basic skills such as eye contact, plain language, open posture, active listening.

Kate Cogan (14:50):

I always think it's like if you're a builder, you bring your tools into the room, you've got your bag of tools. We are our bag of tools, we are it. And I think what you said about looking at people –

Adrian Dabscheck (15:02):

We have to be taught how to use those tools. Some people seem to do it intrinsically. Most of us need to be taught as well as the communication skills. We teach components of the course that aren't usually covered such as illness progression. Specifically Sid mentioned pain management, well malignant cancer, pain management and pain management towards the end of life is quite complex. So we start teaching that very early on.

Kate Cogan (15:27):

I've always found too, and I know this is an issue for a lot of mental health nurses and I teach this a lot about sitting with people to ask the important questions, ask the tough questions. What I've found is if you ask those questions, people tend to relax and think, oh thank God someone has asked me that because I want to talk about it, but I dunno how to talk about it. And this person has created space for

me and my family to talk about what funeral do I want, where do I want to be when I die? It's all those tricky things that people are too scared to ask.

Adrian Dabscheck (16:04):

Yeah, well we do our best to give the students an opportunity with a trained actor to learn how to sit with silence, to give people's personal space to break bad news and to ask those difficult questions. And it's a controlled workshop with an actor who, well the feedback is that we are doing positive things.

Kate Cogan (16:24):

I was going to ask you about the feedback. Do you think they appreciate that aspect of training?

Adrian Dabscheck (16:29):

Yes, the feedback suggests they do.

Sid Bloch (16:32):

It's one of the most popular courses that are run at Melbourne Uni, so you should feel very good about that. If I could say that we adopted a different approach in the sense that we wanted to provide a model of training which would try and meet the needs of this situation. And after a lot of previous clinical work, we felt that the family was, if you like, at the centre together of course with the patient. And therefore we should have a big focus on what the family needs and how to meet those needs. Just in brief, we adopted a method whereby we try to work out what are the family needs, talking to dozens and dozens of patients and their families in a more inquiring mode to get a sense of if you in the situation, what do you feel would be of help to you? And with all that preparation, we devised a therapeutic programme, which was pretty unique at the time. It probably still is quite unusual because of problems with time and getting the relevant players

(17:52):

To offer the time and using a family approach just as an instance of where and how and when all these modes of treatments should be applied is quite tricky. So eventually with the aid of various people who had been involved and the research team we devised, not a popular word I'm sure, but I think it's a valuable word manual, which was considerably detailed. And in that manual were you feel like the requisites of what a therapist who's going to be active in this area should master as best he or she could. And that manual was eventually turned into a book which will be listed in the resources family focused grief therapy. Furthermore, it wasn't just the manual, you don't go away and study a manual and then come back. Oh, I feel competent now. But the 15 therapists involved by the way, mainly social workers and some nurses met with supervisors.

(18:58):

I was one of them regularly throughout the time they were helping the family and in that way the mutual support was intact. I think that echoes the team thing. But this was a more if you like, focused thing on what was going on with a particular family that a particular therapist was involved with. And we had to deal with quite a lot of thorny issues that people felt. It reminds me of Freud's statement, which I quote our own death is indeed unimaginable. Whenever we make the attempt to imagine it, we can perceive that we really survive as spectators. In other words, there's an element of denial. Correct me if you think otherwise, whereby if it was full on it would be very, very demanding and challenging. And the other key feature, which in a way compliments this but makes this Freud quote relevant is the role of empathy. Where does empathy lie? Because if you are trying to empathise with somebody who is in a

situation that you will be one day, but not necessarily in the same circumstances, how can you reach that patient? And my experience tells me, and it's been mentioned before, listening, it's not original, something called active listening.

(20:23):

And another phrase they use is listening with a third ear alongside that is not phrasing your questions in the hope that that's the right question. So giving space for the patient and the family to not pose questions so much. But certainly there are questions.

Kate Cogan (20:44):

I think giving the family space to sort of bounce off each other and you are just almost there as an observer in some cases because sometimes families do with that third person in the room to ask the questions or talk about what it is they want to talk about.

Sid Bloch (20:59):

Certainly bringing your family together is in the hope that they will help each other and talk with one another in a hopefully honest way. The therapist in the experience that I've had or we've had in this programme is that the listener, the active listener therapist in this case is more than an observer because there are a lot of things that are going on. And in a way it doesn't have to dominate the proceedings by any means, but he has to bear in mind what's going on, whether any harms of accruing, which of course that can be possible too. So the family is there because they are living this experience as a group, particularly if a family has been cohesive and the like. But the therapist has some expertise to ensure that things that the patient wants to raise or anybody else will be attended to.

Adrian Dabscheck (21:55):

In the communication workshops we run for the students, we spend a lot of time talking about empathy, active listening. And I do think as a more one-on-one rather, or maybe someone accompanying the patient rather than a family. But I do think the basis of it is how we form a relationship, a trusting relationship so we can then work in that space. I keep telling the students, we're not teaching you to be counsellors, but maybe I've got it wrong. We're just teaching you to treat them like real people. You're not treating an illness, you're treating a person who has as many feelings and things going on in their life as you have, and you have to treat them with respect. And you do that by being empathetic, listening to what they have to say, et cetera. But perhaps I'm underestimating, maybe I'm teaching them to be counsellors.

Sid Bloch (22:52):

Well I don't think we need to label what the person is doing, but the things you have mentioned are very fundamental, aren't there? But I've taught a lot in medical students and psychiatric trainees in this sphere of empathy. And there has been a lot of writing on this too. Empathy is probably one of the most demanding elements in working with people because you have to get into the shoes of the person.

Adrian Dabscheck (23:20):

That's right.

Sid Bloch (23:20):

You've also got to know what to do with that feeling. An example, there was a young trainee who was working with a dying family, a wonderful, beautiful 21-year-old woman who's dying. And on one occasion the whole family were coming around, it was close to the end and the young doctor physician in training was obviously empathic. You could see you could feel it with the whole group. But God, it was difficult. I found it difficult too. And at one point she disappeared. I was caught up with a discussion with the family and I thought, oh my goodness, where's she gone? I'll call her Lauren. And I just didn't know quite what to do. I felt quite helpless. And I said, well look, Lauren's had to go off. I just had to fumble around this something. And where did I find her? Do you think? Probably crying somewhere. She was crying her heart out in the toilet.

(24:16):

She was so embarrassed about it. The shame of it not being able to control. And so this comes back to my point about the carer, well the therapist, the counsellor, and what we do to help them get through.

Adrian Dabscheck (24:32):

There's no doubt it's a very challenging time of life for the patient but also for the –

Kate Cogan (24:39):

– clinician.

Adrian Dabscheck (24:39):

– clinician.

Kate Cogan (24:41):

And Sid, I found that invaluable working in your programme where we had supervision, if that's what you want to call it, weekly. We could come in and talk about our distress of what we were seeing because you can't unsee what you've seen. And even just talking about any judgments that we might've had and trying to unpack those and make sure they don't impact on the care that we are giving.

Adrian Dabscheck (25:00):

I tell the students that a lot of this is the work of being a doctor. I teach medical students, it's the work of medicine. You may have all the technical skills, but it's important to communicate well and accept that what you're doing is important work. And that we distinguish between empathy and sympathy. Sympathy is a waste of time in a clinical work situation. And again, just to emphasise the importance of teams for our work to support each other. Like a dying 21-year-old,

Kate Cogan (25:33):

It's heartbreaking.

Adrian Dabscheck (25:35):

And at the children's there were very small young people dying and you do need team support.

Kate Cogan (25:42):

You do. I can remember sitting with her mother once whose 27-year-old son had bought a unit and was working on the balcony, repairing it, and the balcony collapsed and he died and she was referred to me.

And at the time I had a 27-year-old son who was also renovating and we ended up crying together. And that was after the work that I had done with you, Sid. And she felt quite comforted by that, that someone else could feel that pain and share it.

Adrian Dabscheck (26:10):

One of the things I tell the students is you should never say I understand how you are feeling. Perhaps you could say, I can't begin to understand how you're feeling.

Kate Cogan (26:18):

Absolutely. I use that phrase an awful lot. I can only imagine what you might be feeling, but I don't know.

Sid Bloch (26:25):

That's right. Can I raise one or two things which are particular and where there is some writing on this where issues arise. How long do I have? That's one question. I've got one or two others that are prominent.

Adrian Dabscheck (26:40):

Well prognosis. The longer the expected time from death, the more challenging and inexact the prognosis is as death approaches. If it's within hours or a small number of days, it's relatively easy, but the further out it gets, it's very, very challenging and doctors are invariably inexact. I tend to find working with experienced nurses, they seem to have a better intrinsic feel for it.

Kate Cogan (27:07):

I think you might be right. I often feel like I can sense when we are close to death.

Sid Bloch (27:12):

In the work we were doing, we asked our oncology colleagues, it was all about cancer. That was not easy. But if we took traumatic deaths, it would've just made life very complicated. And the average age of the dying person was high fifties, late fifties. So any children were in their twenties, usually young adults with children it would be entirely different. But in those situations it was arbitrary. We asked our colleagues in oncology, can you refer persons? They only worked essentially with the patient. They might've seen the family, but not very often, how long their terminal condition is going to endure. And we set a time limit of six months. So it was quite a long passage of time. Furthermore, they didn't all go six months of course, and some went beyond six months. But we also went beyond the death. And my interest began with family grieving. And of course there's anticipatory grieving where you lodge the process before the death itself. And that went on for usually some months, sometimes quite short in terms of time and also in terms of the intervention.

(28:30):

It wasn't a full therapy. And time became quite considerably important, both in terms of how long this was going to go for and how long should it go for if it's not impending within days. So it's tricky. Is it?

Adrian Dabscheck (28:47):

It's very tricky.

Sid Bloch (28:48):

But would you answer the question, how long have I got? Because in the death of Ivan Illich, which we discussed in another podcast recently, and it's almost like paired up with what we're talking about today, the patient, Ivan is pretty concerned about that initially until he comes to appreciate that it's not too long a time before he will die.

Adrian Dabscheck (29:11):

So you're asking me if I ever inform patients.

Sid Bloch (29:15):

But I bet you don't.

Adrian Dabscheck (29:16):

No.

Sid Bloch (29:16):

Well, but no, if you've asked, I mean, are you asked by the family members too?

Adrian Dabscheck (29:24):

You often get asked. First of all, you should never put a number in front of it. The number is invariably going to be wrong. And I think the best you can do is in my situation, we don't normally talk about years. We talk about months to many months or weeks to months.

Sid Bloch (29:41):

Not days?

Adrian Dabscheck (29:42):

Days to weeks, depending on the situations, days to weeks or hours to days, or I think you should really bring important relatives in because it's imminent. That's the best we can do.

Sid Bloch (29:54):

And there also a lot of practical issues. The dying person wants to be involved with, even the type of funeral and so on and so forth.

Adrian Dabscheck (30:02):

Most often the dying patient hopefully has made those wishes known beforehand or who has an advanced care plan, which is the preference.

Kate Cogan (30:11):

Well, sometimes they quite often, they don't.

Adrian Dabscheck (30:14):

So then the family fulfils what they think will be their wishes. And if they're of a certain religion, that makes it a lot easier because there's a process, a known process.

Kate Cogan (30:26):

That's why I think, see, the programme that you developed gave us as therapists lots of time to explore all these avenues. We had six months prior to death,

Sid Bloch (30:35):

But it wasn't always six months. But yeah –

Kate Cogan (30:37):

It wasn't always six months.

Sid Bloch (30:40):

But we had time, time was on our hands.

Kate Cogan (30:41):

To go through lots of these things to resolve conflicts. Not every family member wanted to come to the session, but I had many that did come and they were able to resolve some of those issues, which was wonderful for them moving forward post death.

Sid Bloch (30:56):

Well, you've raised another point of great relevance.

Kate Cogan (30:59):

We're running out of time.

Sid Bloch (31:01):

Yeah, time. We need more than one session obviously, but the role of the therapist in dealing with conflict, because you don't always get an amiable calm family. And for that reason, I'd just like to bring up the question of are you going to work with every family because that's the right thing to do, or will you select families where the doctors involved oncologists and the like, feel there are troubles here and we need expertise, which we have not mastered. Families that are dysfunctional. It's not a great word, but in shorthand it is.

Adrian Dabscheck (31:40):

You can usually identify those families and they're the ones that we would anticipate that they would have complicated grief and we would refer to community bereavement services.

Sid Bloch (31:51):

That's grief after the death.

Adrian Dabscheck (31:53):

Yeah. Beforehand, it depends the situation of work. But if you have access to psychologists or psychiatrists, we would identify patients or families who needed assistance. But realistically, the majority of families I dealt with over the last 20 ideas manage pretty well most of the time by themselves with their own resources. They enlist help, assistance as they need. I think we shouldn't underestimate the strength and resilience of most people that we deal with.

Sid Bloch (32:30):

Yes. Well, you raise two points if I may just interact with them. So one is not all families need to come to a team of professionals as if to say, look, there's something wrong with you guys and so we're going to do something about it. And in our work, we found that most families were in that group, at least half of them and the other half there were issues. And we were able to determine to a degree what those issues were because we screened them. Now some people would say, oh, every member of the family, and we found that conflict, failure to resolve, you can have conflict which can be resolved by them themselves, but that's very difficult. The other one was they were not expressing their feelings of deep thoughts. And so there was very little real communication. So if you like expressiveness is what we called it. And the third thing was cohesiveness. So how does a family actually work together –

Kate Cogan (33:34):

– stay together.

Sid Bloch (33:35):

So if any one of these was scored in the range of, oh, there's trouble here, we assumed that they would need some help. But if all those scores, this is an instrument with great reliability called the family relationships index, don't have to go to that now, been around for a long time and which I learned about way back when I was starting out in this work. So that's a question of trying to screen. And I know screening can sometimes be a bit just depending on numbers really and also depending on critical assessment.

Adrian Dabscheck (34:14):

So you bring up screening, my emphasis was obviously on a very different component of death and dying, relieving distress, pain and other symptoms. And it's been very well shown that unless you screen for pain, especially non chronic cancer pain, you'll miss so much. The patient dying of cancer with significant pain may sit there apparently quite calmly, but if you show them a pain scale, they can have eight out of 10, nine out of 10 pain. But they're so used to living with it

Kate Cogan (34:50):

As well as that, the grief factor, there's no right or wrong way to grieve. I see a lot of people that think they're going mad or they feel quite suicidal because they're feeling like this. But grief is a very individual process and cultural, lots of cultures have different aspects, but to try and normalise the grief that everybody's journey is different.

Sid Bloch (35:10):

Well, this is in a sense why we adopted this type of procedure where we try and identify families, yes, individualised, but a family in their own, as Tolstoy once said, all normal families are alive, but abnormal families cover the whole range. So trying to establish which families really need care. And then this is

before the death, by the way, rather than grief. Look, the other thing you mentioned, one of you or both of you, religion. And I'd like to extend that to let's say spirituality. And I was just wondering, I found it quite difficult in this research project and also in supervision of the people who were involved and in my own self as a practitioner, clinical practitioner, how to deal with the spirituality, if it's present.

Kate Cogan (36:01):

I think we might keep that for another date. I think we're out of time. And I, I've got your comment where you said, I wish we had more time to do justice to the most profound experience virtually all of us will undergo as carer of a relative or friend facing death. And of course of every one of us, the challenge of dealing with our own dying will come.

(36:23):

We've covered a lot of territory here today, gentlemen, which we hope has been of interest to you, our listeners, to stay up to date with MHN podcasts, make sure you subscribe to MHPN presents. Thank you for your commitment to multidisciplinary care and lifelong learning. You've been listening to myself, **Kate Cogan**,

Adrian Dabscheck (36:44):

Adrian Dabscheck,

Sid Bloch (36:45):

and Sidney Bloch.

Kate Cogan (36:47):

And I'd just like to finish off with a lovely poem I read last night. They say, time heals, but the truth is, time only teaches us how to carry the weight of missing someone forever. Thank you, gentlemen.

Adrian Dabscheck (37:01):

Thank you, Kate.

Host (37:04):

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