Everyone-Included Research

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Proem 00:52

Research follows life. Life comes before research. My diagnosis of Multiple Sclerosis preceded my need for research. Let's talk about comparative effectiveness research (CER). CER is simply research that tells us that treatment A is more likely to be helpful than treatment B for a particular group of people in a particular set of circumstances. Before researchers conduct clinical effectiveness research, people have had symptoms, tried to manage those symptoms independently, got diagnosed, and then tried different therapies prescribed by their doctor. Some doctors tried treatment A, some treatment B, and even some treatment C. Researchers, clinicians or patients wanted to know if A was better than B and found funding to do comparative effectiveness research. Even if years of research occur and get published before I get diagnosed, my life happens before research becomes relevant; relevant in the context of my life, my circumstances, my conditions, my genetics. This perspective is the cornerstone of my advocacy for person-centered research.

Introducing Amy Price 02:34

I'm delighted to introduce my guest, Amy Price, a senior research scientist at Stanford University in California with the AIM Lab the Anesthesia, Informatics, and Media Lab.; Amy is also a research editor with the British Medical Journal (BMJ) in the UK. The BMJ is a patients-included medical journal. Everything Amy does involves putting laypeople with researchers and finding out how end-users, clinicians, researchers, and systems can work together and benefit each other – an everyone-included model. I first heard Amy's name when the BMJ recruited me as a patient reviewer. I invited Amy as a guest because I knew that she was on the forward edge of including patients in research. She uses her positions and experience to advocate for patients and caregivers and mentor other researchers worldwide. One of the challenges of including people with lived experience in research is that they come with all their emotions, grief, and life. Amy's husband died recently of COVID-19 acquired after admission *to a hospital and then rehab facility with a severe break in his femur. I'm grateful that Amy feels comfortable sharing that tragedy with us in the context of patient-included research.*

Health Hats: Amy. Thanks for joining me today. I think Brian Alper introduced us.

Amy Price: Yes, Dr. Brian Alper is a fabulous, wonderful man who created a point of care system as a medical student because he had trouble recognizing and remembering medical terms. When he found out that other people had the same problem, that blossomed into a whole beautiful point of care system, I used that point of care system because I took an evidence-based healthcare masters at the University of Oxford. I was one of the few people that was not an MD. Dr. Google only goes so far. I found that the point of care system was a wonderful way to get me up to scratch on technology, terminology, and the current treatment options.

*Clinical point of care (POC) is when clinicians deliver healthcare products and services to patients at the time of care. The electronic medical record is a point of care system. Dr. Alper created **DynaMed**, a clinical decision support tool that combines the most current clinical evidence with guidance from leading experts inzcc a user-friendly, personalized experience. With **DynaMed**, clinicians can find answers to questions at the point-of-care with unprecedented speed. I invited Brian to join me in a mastermind support group. He recommended that I include Amy. Also, you are going to hear the term PI and co-PI. PI is Primary Investigator, the leader, or leaders of a research project.*

Patient-caregiver participation in research. Why care? 07:01

Health Hats: Tell me about what patient caregiver participation in research means and why anybody should care?

Amy Price: The biggest challenge in research can be because you design something for someone, but you don't know that person's needs. They are the only ones that can tell you those needs. You can't just measure those needs objectively and think that you got it. For example, I could measure you for a full set of clothes. Those clothes could fit you perfectly. But they might not be the clothes that you want to wear. The texture might not be what matches your skin. You might not like the color. So then, if there are things in those clothes, even though they fit perfectly from a quantitative perspective of measuring, then you won't use them. If that was a drug and you're supposed to take this drug intervention three times a day, and the first time you have some feelings about it, some side effects, and you think, 'let's halve the dosage.' Soon, that drug that was supposed to remain in your bloodstream to make a difference, can't make a difference anymore. You can't tolerate the drug. This happened frequently with people in mental health. The first mental health drugs did stop people from having hallucinations.

Health Hats: Like Thorazine, Mellaril, and stuff like that?

Amy Price: Yes, especially first-generation drugs. People thought they were a great success because it meant that they could reduce the number of institutionalized people for the first time in history. But people that were having those problems with mental illness felt that they had more freedom in the institution because those drugs caused them to slur their speech, gain massive amounts of weight, unable to maintain an intimate relationship, had dry mouth and eyes. They said, 'yeah, I'd rather be crazy because that didn't bother me. That bothered other people. I don't want to hurt anyone, but at the same time, I can't live my whole life like this.' They could have studied that at the beginning, and they could have developed drugs that solved those problems, which they have now for the most part. But in those days, those drugs shortened the life of people for many years. So, that was a fail. We see many times where interventions, pharmaceutical drugs, and medical devices, the problems are seen very early in people. Still, because the study has an agenda, the study goes on, and those particular things aren't recorded. That's how we get more recalls. That's how we get challenges and implementation problems because if the intervention doesn't match the person's lifestyle or what they feel comfortable using, it will be cast aside. Then it's the same as not using it at all.

The right person for the right job 10:40

Health Hats: Okay. So that explains why people should care about it, but that affects them on the outcome end? How about people becoming involved in research? The challenge of recruiting participants - sometimes called subjects - is one thing. But if you're talking about recruiting people to participate, to inform about life in general, where the fit isn't the necessarily the thing, but the color and the texture and all that. Who is it that gets involved in that kind of participation?

Amy Price: In the studies that I do and that we see at the BMJ more and more, all kinds of people get involved in research for different reasons. The thing is to provide opportunities where people want to get involved. If I say to you, 'I have a job scrubbing toilets, it's a wonderful research position.' Would you like that job? You think. 'no, not today. Get me out of here.' So, it's up to me as a researcher to share tasks that you would find pleasing just as it is with any part of a business or our family or the life you're building. You're building a useful relationship, a relationship where there's give and take between what you can do, what you can't do. So if I'm a patient and I'm helping with a research project, I may want to know something about statistics to be more informed about the study, but I do not have to be the team statistician. I think that we err because people either think that they're just there to share their experience or believe that they're the sun, moon, and stars for the team.

Neither is true. In a good team, every piece does its work. The challenge is if you look at a car, for instance, a car has parts that do different things. If I try to make my engine be a tire, that's not going to work. It's the wrong shape. So, we have to sort out what shape we take in our research studies and what shape we take when involving people, researchers, and lay researchers, our patients. They are a part of the team, and they're a part of that relationship. It's not one size fits all. You don't just pick up a patient and put them in research and say, 'I've got a patient that's good enough.' No, it's a specific patient that fits those research needs. At one point, you might want someone very new in their experience because that's what you need to answer your research question, and that's who you think could be more helpful. And then another time you may want very experienced people. It's the same in any other kind of relationship, the give and take.

Health Hats: I like that because I'm thinking about a conversation I had with somebody from the University of Michigan Performance Improvement Department. Their philosophy was, 'anybody who wants to be involved, the answer is yes.' The challenge was developing these multi-tiered systems where the bulk of people were survey responders - we do a survey, and they'd respond. But then some people were more testers, trying out different solutions, different potential solutions. Then there were people good at communicating and sharing stuff on social media. Then some people were good leaders, and they could be a Co-PI. I loved that they were going, 'how do we get to yes for everybody?' and then design it so that we have many different tiers. But the challenge was building and funding infrastructure. You don't just do that by waving your magic wand. It takes work, and it takes an intake system, a support system, technology to do that assessment and offer those varying opportunities.

Co-production. Sweet. 15:48

Amy Price: Okay, that's true. Consider this: you don't have to build all at once. I suggest when people start with co-production public and patient involvement,

Health Hats: What does co-production mean?

Amy Price: Co-production means that you work right alongside the researcher. It's a form of public and patient involvement. I prefer having people working with me through the study. Some people follow the model you were speaking about - not doing what they're good at. Often, I give patients one task to do. I know if they're faithful to the task just the same as I would with anyone I had on board, employing them or as a part of the research team. And then, as trust builds, I would give them more, but I would make room for that in the study. So, it's okay to start small. I think it's preferable because you can see what you've got and grow together when you start small. It's like a family. If you have one child or two children in a family, you can meet those children's needs. You can see them as individuals; they can grow with you. But if suddenly you are blessed with quintuplets, then that's a different problem; it's a whole different world. If I was blessed with quintuplets in my family, then I would say, ‘okay, this is what we've got in front of me. This is what I'm going to work. I'm going to love those kids, and I'm going to give them the best childhood that I can, imperfect as I am. I'll try to be their mom,’ and their dad would come along for the same journey. But I wouldn't wake up one morning and say, 'The next birth I have is going to be quintuplets. Let's celebrate that.' No, I would prefer one at a time. Sometimes we make those adjustments, but it's okay to start small, and it's okay to start with what you need. If it's your research project, you know what the needs are, so to seek out people who might have those particular qualities rather than change your research project to meet the needs of whoever volunteers.

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Community-based research 19:11

Health Hats: Is your research mostly clinical research, meaning, either medical hospital, medical, clinic or is it also community-based research?

Amy Price: That's a great question. I do everything, clinical and community. I do everything and find that they work well together because one of the barriers to research is that sometimes clinical and social care or communities don't talk. That's a great gap. You can always find when you're moving through those areas, anytime that you can join them together, it's a plus for everyone.

Health Hats: Now, in this pandemic, you can see where that gap is biting us in the ass. When I looked at a lot of these collaborations that are going on, these fast track research projects, they're very heavy in the save-the-life arena, as it should be. On the other hand, so much of managing this pandemic for lay people happens at home or in the community. There's not that much happening in the community right now. I think it's partially because we're not good at it. You can ramp up familiar stuff, but it's hard to ramp up stuff that you're not familiar with.

Amy Price: I'd have to agree with that. With the pandemic, you have the fear aspect, and people don't like to make new friends when they're fearful.

Health Hats: That's for sure.

Learning from tragedy 21:13

Amy Price: My husband died of COVID. A healthcare worker infected him. The most difficult thing was not seeing him. He went into the hospital with a broken femur. And we watched him die over FaceTime, and that was horrendous and unnecessary. There were many ways that it could have been arranged for visits to take place. We had to make end-of-life choices on behalf of another person that you see through a phone screen. It's an unbelievable experience. I see that repeated worldwide, yet I don't see people getting together and saying, ‘how can we as patients, as clinicians, as systems do this better?

How can we make this work?’ Everyone laying their cards on the table We're the system; we're afraid that we'll get sued. It will cost us more money. The clinicians, if we increase risks and we don't have PPE. But I, in my case, the World Health Organization gave me the PPE. I had people to don and doff. I had the training. I had people interceding for me when they would not let me in the hospital. I considered breaking in because it's my husband. It was not right. But at that particular time, the ward was so closed that it was face recognition badges that were changed by the day. Sometimes even the smaller things, like when you pick up someone's belongings, they had us wait. It happened twice because it was a rehab facility and then a hospital. Both times we had to wait three and a half to four hours in the Florida sun for someone to give us the belongings. We were isolated from other people who were also waiting for the same thing. The belongings are given to you as biological waste. The very last thing that you have of your loved one is a garbage bag full of stuff. I think we can do better. I think it could be better packaged. I think people could have some counseling before they go. There could be some mentorship; some making people welcome even at a distance. You could even have mini ceremonies going on for people, and you could know it's going to take four hours to get this together. Thank you for checking in. If you check back just like you do at Walgreens or Walmart to get a prescription. If you check back, we will be ready for you in 3.2 hours. Is there something else you can do for that time or even send them a letter ahead saying, this is a process. This is how long it will take. And the kindness in returning those goods to the patients is critical.

Health Hats: I have been an ICU nurse and an ER nurse, and a quality improvement professional. What goes through my mind is that the gap between what people need as their loved one is going through this and the gap between what people need or the questions they have and what we're working on. Where our attention is, where the professional's attention is, there's such a gap.

Amy Price: That's the problem.

Health Hats: It seems like with COVID, all the challenges that we have, whether it's clinically, relationships, research, it's just all the same challenges on steroids. They're magnified; they're exploding. It's like a magnifying glass to look at the wart or the elephant or whatever. Yes, it's a challenge. Now I'm on calls with patient family advisors' networks. People get together and talk about what they're dealing within a particular organization where they sit on the patient family council. Much of the conversation is about family presence for people with sick people, and the range is from crying rage to sobbing frustration. Almost nobody is talking about we tried this, and this worked, this didn't work, it's like they're not even to the point of trying stuff.

Amy Price: Yes, exactly. When we try it, there's such an overwhelming sense of grief we don't share. For example, in this particular place where my husband passed, in that hospital, there was one iPad for the whole floor for the entire ICU.

Health Hats: Oh, my God.

Amy Price: One iPad. One wonderful, amazing nurse ICU nurse - yay, nurses - decided why don't we just put his phone on his IV pole, then all we have to do is turn it on. And they left it on the IV poles. We would call the desk and say, 'please turn on the phone.' Then we had the opportunity to speak with my husband or sing to him or pray or read him something when he couldn't speak anymore or just watch him, just to be there, to be a human presence there, because we couldn't actually be there and it was like more precious than anything. Then another time they said because of different strokes, he might feel fearful, or he might not be able to recognize the people with him. So, I asked, could they pretend they were me, just catch him nicely. They were so kind, and they did that. I remember one of the neurologists shared with me how she hoped he could get well and the barriers in the way of getting well. Then she just cried. It was real. I instantly loved her. I instantly connected because it was human. That was in contrast to another provider selling hospice like it was a used car. My feeling at the time was my husband knows the people in the ICU, even if he's not fully conscious. He knows the people touching him and caring for him. He needs to be in an atmosphere where he feels familiar. But then, of course, the ICU is quite full, and we have to make room. I became very selfish. I said, 'the only person I have to make room for and care for is my husband. We've been together for 49 years. And that's where my focus is. He will not be moved.'

Health Hats: How do you think this recent experience you've had with your husband and COVID changed how you think? If you take three steps away from yourself and look and see how it's affected your work now, as a researcher. Do you feel like your glasses are tinted differently or they're a different prescription? How do you think the work you're already doing your work will be different? You're already a very patient-caregiver focus in your work. But this can't not affect you massively.

Amy Price: Oh, that's a different question to answer. I think that grief has several stages that people go through. I don't believe until you go through the other end that you realize its impact on your daily life. I probably have less tolerance for unkindness and hierarchy. The compassion for patients and people on the other end of treatment and the clinicians who treat them are often horrendously overworked and underappreciated. I don't know that that has changed. Unfortunately, I have a disrespect for or a growing disrespect for systems and politics and how people's agendas shape evidence and not by actual research evidence. And I have a greater passion that we as human beings, no matter whether we're researchers, whether we're clinicians, whoever we are if we have to make decisions on things, have the right to have evidence knowledge available to us. And it doesn't matter how people feel about explaining that to us. It's not their prerogative to have feelings about that. I think that the right to information should be a human right because it allows us to make informed shared decision and a decision can't be shared unless it's informed. It's only manipulation if it's not a shared decision, or the decision is to not decide at all. In terms of decision-making, it's important to respect the individual as to how much of the decision they feel comfortable in making, rather than have some preconceived idea of how much of a decision they should or shouldn't make, how much information do they want and to do everything in our power to provide that. I've had some misgivings in research and not done well about working day and night and boundaries. I'm not that good at, but I have to get better. Those are the major changes that I can see right now, but I think it can also be like a growing child. We have our children. We don't see how much they've grown until their pants are getting too short or they're growing out of things. Often other people can see changes in us, but we don't necessarily see those changes.

Build trust, find cracks, walk through the door 34:12

Health Hats: That's fair. So, I'm going to turn it around a little bit before we wrap it up. I'm now on the Board of Governors for PCORI (the Patient-Centered Outcomes Institute), and it's an awesome responsibility and opportunity. So, as a researcher, a patient, a layperson, considering research, where should I focus my attention with PCORI to affect strategy for this patient-centered comparative effectiveness research?

Amy Price: That's a very interesting and important question. And I don't know if you'll like the answer to this, but I find that it's who you are that makes those differences in strategy and in changing policy. And when an open door comes up, you'll see that there's a gap, and sometimes you can walk through that door and make a difference, and that's the time to do it. And then there are other times where you could speak up, but no one's hearing. So, at that point, you're creating a presence; you're building trust. That's okay as well. So, in anything like that, watch for your moments because there are certain places where you will be able, where you're destined to make a difference where no one else on that PCORI Board can. You have unique capacities, and you were chosen, to do this. If you asked me, as a researcher and someone who's involved in co-production, what would I like to see, I can give you my shopping list.

Health Hats: Hold that thought, because I want to hear at least a couple of things on your shopping list. But I want to tell you that I do what you're saying. Like you, I'm a seasoned person and I've been a change agent all my life, and I think what you're saying about trust and opportunity and stepping through the door when there's a crack to step through, rather than trying to identify this is what I need to accomplish, blaze forward with that. I think that's very smart. Okay, give me two or three things that are on your shopping list.

A shopping list 37:12

Amy Price: On my shopping list: First, co-production and patient involvement. Fund it with enough money to make a difference. Fund it with enough money to train researchers, and clinicians together on the project that they're working on, fund it so that there's a future for lay researchers on that project to move forward into another project, maybe with the same team. Instead of just a research project, you are building lives; you're building a future, you're building a system and widening the scope. There's very little in PCORI that is user-generated in terms of the original ideas. So in the original ideas, why couldn't just as a test, some of those ideas, the big ideas, the ones that are going to be funded big because you can apply for a $10,000 seed grant, and it's wonderful. It's wonderful that they're available. It's wonderful that PCORI does things like that because it does give people a start. So, I'm not making that small in any way. Congratulations, let's do more of that. But then why not take a big chance on a big grant where somewhere a difference could be made and completely something that was comparative effectiveness that a group of end-users decided. Then maybe they brought in the researcher and the researchers as consultants. And the clinicians are the consultant. I think it would be amazing to see to see something like that. I don't know if PCORI is ready for that. But I believe that one day they will be because there's good people like you also now, there are good people at PCORI. People fail to see that they compare it with other systems, like the NIHR and the Australian systems that have been in place for so many years with some kind of level of public and patient involvement. In the US, we had nothing. PCORI came and they have done landmark things, and they have outdistanced with less money many of those other kinds of seasoned organizations. So, I really respect and admire the work of PCORI.

(The NIHR is the National Institute for Health Research, UK's largest funder of health and care research and provides the people, facilities, and technology that enable research to thrive)

Health Hats: Those are good ones, really good ones. Thank you. Do you have a third one?

Amy Price: Oh my gosh. I get three wishes? Yes. I would love to see organizations that would step forward - because one of the things about grant funding agencies is that they're very responsible for the funding they give out. They must get outcomes back because otherwise, it's not coming to them again. So, they can't just say 'here patients' to people who have no experience and don't know what a statistician is. 'Here, just take this huge project and run with it,' right? Because they're responsible. The funding agency is responsible to the taxpayers and to other funders. They're responsible for the outcomes, so they have to have outcomes. Let's not forget that. But what if certain organizations stepped up and said like I know for sure that at the AIM level at Stanford, we would do this, where you would step up and say, 'I will take a major project. I will be a mentor for a co-investigator as a patient on the major projects, and we will be with them all the way; we will work together.' That would be my third wish. I would love to see that.

Equity in research, in life, respectful relationships 42:07

Health Hats: When I thought about going for the PCORI Board and was accepted, it was like, okay, so what is it that I'm here to accomplish? If I had to say one thing, it's about health equity. And I think the things that you've talked about are key to that, key to that happening. So, I appreciate this.

Amy Price: Yeah, I hear so much conversation with buzzwords. Buzzwords like *level the playing field*, *health equity*, *make everyone on the same hierarchy for a season*. To me, if you're using hierarchy and power in the same sentence, that's a fail. It's more like a relationship. When I look back to my long marriage, that relationship's success wasn't that we strove to make each other equal. The success of that the relationship was the relationship that we built and the relationship itself created the respect, the respect and the equality and the partnership and the trust and all those things are the things that are necessary for people to work outside of hierarchy. Because then the rules, so to speak, aren't broken because they're inborn, and you would not break those rules because you don't want to hurt the relationship, but if they're hierarchy driven, that's a rule. How solid is that rule? How far can I push against that rule? And all the time that we're doing this, trying to find out what rules are real and what rules we can break and ask for forgiveness for later. That's is wasting time, and it's time that's taken away from building together in relationship. Does that make sense? To me, real equality is in respecting each other and even more than even the kind of respect that covers one another's backs. So, I have good days, and I have bad days. In my good days, maybe I'm a star. On my bad days, so not much. I probably don't deserve a relationship in terms of having that because I deserved it. So, my part is to try to minimize those days. But when I can, as a friend, as a partner, as someone that's working with me, will you cover me? Will you love me for who I am? Not in, not somebody you want me to be. Because if you love people as they are or work with them as they are a partner with them, as they are, whatever words that you want to use, then as you do that, their strengths will come out, and they will become everything that you wanted them to be. That will unleash power and possibilities and capabilities and loyalties in them that they never even knew they had themselves. And you didn't know. And sometimes we can see the potential in other people they can't see in themselves. And as a friend, I can build that potential and help you see; you can do this. A really important part of health equity is respect, the relationship, and the permission to be different. I don't have to be like you; I don't have to think like you. I only have to respect you. I have to care for you. I have to listen to you. And if I listen to you and listen to hear not just to respond, but really, but listen to you, then that will change me that's going to change me. Cause I'm going to see things in me that need to change based on what you said. And if you've truly listened to me, the same things, the same thing's going to happen for you. And that builds a force, and it builds a team, that I think nothing can break. But it's not easy. It's hard work. It's hard work to co-produce things. It's hard, it's easy to do it's off, but then you've got another person they think differently and, and then you want to be kind, and you want to be co-producing, and then you realize that actually, you're not co-producing at all. You're just expecting everyone to do it your way. And you're looking for people that will collaborate or cooperate on your system. And you don't even know how they think about that idea. And I can't tell you the number of times when I found myself like that. And I thought, I've got what I want, but do they have what they need or what they want? and so that's all for me, that's part of the, that's part of the journey. That's part of the co-production journey as part of a partnership's journey, and we gain more. So, you can see things that I'd like to do things where I might be really weak. You could sit there and say, yeah, that Amy, like she's a real loser. I can't believe what I had to say. You have to explain that to her. She's so thick. Or you could explain it. You could just explain it to me. And you do the strong part. One of the beautiful things in the area of grief, one of the beautiful things that came from that is sometimes in the early stages of grief, you're not really doing your job. And the workload for everyone else doesn't lessen. And yet I found that people just quietly picked up tasks or made another way to do things in some areas. Like to create space and freedom, and that's also a part of partnerships to get anyone to work with me. almost anyone, most people, a lot of people when I'm at the top, got lots of things going for me. Everyone will come for the ride, but when the ride gets bumpy, who's left? The people that I want to work with, the people that I want to partner with for a lifetime, are the people that will stay for the ride, whether it's bumpy or smooth. I'm also fully prepared to stay for the ride with them, whether it's bumpy or smooth. It's a two-way street. In marriage, people talk about living 50/50. Everybody has to be 50/50. My husband and I decided that's wrong because each person has to give a hundred percent. And when you both get a hundred, you get an amazing synergy. But as soon as you start measuring how much I've been on it now, you've defeated. You've defeated the purpose. You've fallen into the hierarchy path.

Health Hats: Wow, this has been a lot. Thank you. This is great. Thank you very much.

Amy Price: Oh, thank you so much. It's been such an honor. This has been like talking to a friend.

Health Hats: Yeah. Good. Good. Guess what? We're on our way. We will talk again. That's one of the nice things about doing this is. I'm a nurse, and one of the things that I've always loved about nursing is that I’ve had the opportunity to have brief intimate moments with people. It's such an honor and so gratifying and enriching. I've missed that once I got into administration and consulting and got away from the direct care. Oddly enough, I find that this interviewing can be like that.

Amy Price: I actually found this interview healing.

Health Hats: Oh, great.

Amy Price: I find it healing and calming in a way. It made me reawaken something on the inside, which is beautiful. I'm so grateful for what you're doing in this space. You do make a difference for people. Every place that your feet have landed, the nursing, the administration, the policy, the strategy, you've just done whatever you need to do, make a difference.

Health Hats: I try. I try.

Amy Price: Yes. And I think that many times do you know that there are people in my life that changed my life with a word, and I didn't realize it until years later. That word never left me or that impression or something that I saw. I think that it's the same. I believe that you're changing destinies with those direct personal moments. Thank you. Thank you.

Reflection 52:08

Wow, a rich and enervating conversation. Person-included research, co-production, tragedy, grief, health equity, relationships in life and research. After I completed this interview, I thought research and tragedy - what’s the through line, the story here? For me, like Amy, I have a 45-year marriage that’s the epitome, the model for co-production with respect, partnership, growth, and wonder. It’s a high bar for everyone-included research. I also think that passion, enthusiasm, and activism in relationships, research, and advocacy have the inevitable consequence of disappointment, grief, and exhaustion. One doesn’t come without the other. Mutual respect and support go along way to keep the fires burning.

Thanks for this chat, Amy. And thanks to all of you pushing and pulling for everyone-included research. We have so much work to do. Onward!