On-the-Job Training Opens Palliative Care Doors

BY KERRI WACHTER
Senior Writer

TAMPA — It's possible to start practicing palliative care medicine, while still learning how to provide it, according to two physicians who have made successful switches from other specialties.

Dr. Tina L. Smusz was once an emergency medicine specialist, but is now the medical codirector of Carilion Hospice of New River Valley Medical Center in Christiansburg, Va. She and Dr. Christopher W. Pile of Carilion Roanoke (Va.) Memorial Hospital described their experiences last month at the annual meeting of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

Retraining might be one way to help ease the growing need for palliative care specialists, according to Dr. Edward Vandenberg of the department of geriatrics at the University of Nebraska, Omaha. "The need for palliative care services in rural areas will rapidly outpace the need in urban areas on a per-person basis. Rural nursing homes will carry a significant share of the burden," he said in an interview. The percentage of individuals over age 65 years who live in rural areas and need chronic care exceeds the percentage in urban areas. In 2004, the proportion of the population over age 65 years in the United States was 12.1%, while the proportion in rural Nebraska, for example, was 17%.

Both Dr. Smusz and Dr. Pile said that they were able to start practicing palliative medicine—while still learning how to provide it—by establishing relationships with several facilities in Southwestern Virginia simultaneously.

Dr. Pile was a practicing family physician when he started as the volunteer director of palliative care at Wythe County Community Hospital and its Hospice of Southwest Virginia. The area served by the hospice and the 104-bed acute and subacute care hospital includes four counties that have a total population of about 120,000.

Dr. Pile became the hospice's medical director and chairman of the hospital's ethics committee. After becoming certified in palliative medicine by the American Board of Hospice and Palliative Medicine, he gained consulting privileges in palliative care at Smyth County Community Hospital in Marion, Va., and Johnston Memorial Hospital in Abingdon, Va., where he also had contracts for delivering palliative care and ethics administration. Setting up the contracts was important because they allowed him to be paid for administrative time. Dr. Pile advised his audience to ensure that they are compensated for administrative time. "Don't shortchange yourself. [About] $100 an hour is reasonable," he said.

He also became medical director of Valley Health Care Center, a 180-bed nursing facility in Chilhowie, Va., which offers skilled, intermediate, and assisted living care. He also became an associate professor at the Virginia College of Osteopathic Medicine in Blacksburg.

All of these entities supported his training and contribute to his current compensation. "Really it's just a matter of being creative," said Dr. Pile. For instance, when he travels to palliative care training symposia, one facility pays for airfare, another facility covers registration, and a third reimburses his hotel costs. In return, Dr. Pile said he brings what he has learned back to each facility and gives in-service training to every staff member.

Dr. Pile's training has included a course based on the Education on Palliative and End-of-Life Care project, the American Academy of Hospice and Palliative Medicine's hospice medical director course and current concepts in palliative care course, and Harvard Medical School's program in palliative care education and practice. He also received palliative care leadership training under the auspices of the Center to Advance Palliative Care.

Dr. Smusz also works with several facilities in Virginia. Besides holding the post as medical codirector of Carilion Hospice of the New River Valley, she is a palliative medicine specialist there and does inpatient consultation for the larger network of facilities called Carilion Clinic. She also is on the faculty of Virginia College of Osteopathic Medicine. The area served by the Carilion Hospice includes four counties with a total population of more than 150,000.

Once Dr. Smusz realized that she had an interest in palliative medicine, she began volunteering with the hospice and doing home visits while continuing to work in emergency medicine. She became medical codirector of the hospice while she was still retraining. The following year she started to do palliative medicine consultations at Carilion New River Valley Medical Center.

Her training included a Center to Advance Palliative Care course on building a hospital-based palliative care program, training in one of the center's palliative care leadership programs, the same Education on Palliative and End-of-Life-Care course and Harvard program in palliative care education and practice that Dr. Pile attended. She also did extensive study on her own.

Dr. Smusz paid for her initial training herself, but made the money she needed by starting hospice work while in her retraining period.

"Dr. Pile and Dr. Smusz have demonstrated an innovative approach to delivery of palliative care by combining the roles of the practice of palliative medicine with medical directorships of hospices and nursing homes," said Dr. Vandenberg. "For the nursing home, this approach would provide skills and knowledge along with leadership in an area that critically needs improved end-of-life care. Through the medical directorship position, these physicians will not only have the ability to provide expertise in palliative care but also make system changes through quality improvement activities in end-of-life care in the nursing home. Finally, to provide this expertise in a rural environment addresses the areas that need it most."

For those interested in making the transition to palliative care, Dr. Smusz recommended starting at a hospice. "You need to learn frontline ... care of dying people before you ever pretend that you know how to do palliative medicine," she said. Her compensation and training have been supported by all the facilities with which she works.

"The thing that makes this work is the teams," said Dr. Pile. At every facility, a palliative care specialist should assemble a team made up of interested people from various disciplines—respiratory therapists, social workers, administrators, physicians, and nurses. It's the support of these teams that has allowed Dr. Pile to cover a broad geographic area, he said.

Dr. Pile said it is important for a palliative care specialist to regularly reinforce his or her value to rural facilities. He recommended keeping records of the annual number of patient-days spent in hospice and the average number of referrals made to hospice per month for each facility. Data such as these can demonstrate to administrators that having a palliative care specialist available can generate income from hospice services.

Physicians interested in entering palliative medicine have a 5-year window in which they can become certified without the requirement for a formal fellowship. Beginning this year, cooperating boards within the American Board of Medical Specialties will offer a subspecialty certificate in hospice and palliative medicine. Through 2012, candidates without formal training may sit for examination if they have prior certification by the American Board of Hospice and Palliative Medicine or have had at least 800 hours of subspecialty-level practice in hospice and palliative medicine during the past 5 years.

Dr. Pile and Dr. Smusz said they have no financial relationships to disclose. ■

Places to Turn For Guidance

- American Academy of Hospice and Palliative Medicine (www.aahpm.org)
- Center to Advance Palliative Care (www.capc.org)
- Educating Physicians in End-of-Life Care (www.epec.net/EPEC/webpages/index.cfm)
- Program in Palliative Care Education and Practice, Harvard Medical School (www.hms.harvard.edu/cdi/pallcare)

Keep Communication Open When End-of-Life Conflicts Flare

BY KERRI WACHTER
Senior Writer

TAMPA — When conflicts over end-of-life care arise, try to understand the conflict and keep the lines of communication open, said three experts in palliative medicine at the annual meeting of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

"There's no question that conflicts will occur. The question is how to approach them," said Dr. Kimberly S. Johnson, an attending physician at the Duke University Center for Palliative Care in Durham, N.C.

"The challenge for us is to be able to recognize the conflict and the nature of the conflict," said Jennifer Gentry, an adult and geriatric nurse practitioner at the center.

Conflicts can arise when there are different views of the expected roles of family members and of the medical team, noted Dr. Toni Cutson, an attending physician at the center.

Physicians should remember that the family could have a history of problems before the medical team enters the picture. "We're not marriage or family counselors," Dr. Cutson said. "We're certainly not asked to fix these relationships." In addition, the team doesn't always know all of the facts. Even the "villain" has his own side to the story. In the case of an unsupportive husband, he might be trying to protect his children from their mother's illness and decline.

"When you see conflict, you're going to see emotion," Ms. Gentry said. In handling emotions that arise in situations of conflict, she recommends remembering the mnemonic acronym NURSE: name the emotion; understand and relate to that emotion; respect everyone's feelings; support the patient; and explore the emotion by asking the patient and family to tell you more.

"Clear communication and transparency are important tools to resolve conflict," Dr. Johnson said. Take the time to find out what the patient's and family's goals are, and avoid making assumptions, particularly about a patient/family's culture and relationships, Ms. Gentry advised.

When faced with a patient and family members experiencing conflict, Ms. Gentry recommended that physicians do the following:

- Try to understand that each family member might be at a different stage in terms of acceptance of a terminal illness.
- Realize that prior family conflict could be contributing to the current conflict over care.
- Try to define areas of agreement and disagreement to clarify the problem.
- Try time-limited trials of therapies to allow the family more time to make decisions.
- Have follow-up meetings to discuss concerns about care.
- When appropriate, suggest the family consult a psychiatric professional, ethics consultant, or spiritual adviser. ■