



AMSA-VITAS

End of Life Care Fellowship

Letter to a Mentor

By Colleen Fitzgerald

Touro University-California, Class of 2011

Hi Dr. West,

I just wanted to let you know how INCREDIBLY FANTASTIC my experience in Florida has been. Tomorrow concludes our first week here. We have had two days of very informative lectures, followed by two days of our very first rounds!

Our Hospice Medical Director took his time explaining each and every case to us. I could not ask for a better first experience with Rounds. The second day, we were each assigned a patient and presented the case to him!!! In the past two days I have: learned about the use of atropine for congestion seen the administration of sublingual MS; seen active and inactive peg tubes used for feeding and meds; learned sometimes it's best to leave inactive peg and picc lines in the patient for their maximum comfort; seen the effects of brain metastasis with subsequent one-sided facial paralysis; seen active dying, and cheyne-stokes breathing; learned how to declare death and performed such an exam; heard murmurs, insufficiency, rales, etc.; learned about the staging of decubiti and have seen them up close, also the special sponge bandages and air mattresses used to help decrease contact and pressure; encountered patients with c. diff and MRSA; felt an end-stage breast tu-

mor; felt and heard an AAA; seen a 48 year old man who had been beaten to the point of extreme brain damage and close to death; learned about contractures; seen foot drop from lack of board use when bed bound; seen a successful inpatient discharge; seen a son not willing to accept that his mother is passing away; seen a family divided about the best care for their mother; seen a gangrenous toe; and felt for extremity warmth and pulses.

I cannot believe how much we are learning, and it is completely painless (except for my feet).

The fellows all get along and are developing close friendships. We have all joined a gym next to the beach, and enjoy going each evening. My spin bike is outside on the roof under a canopy with fans, overlooking the ocean! And when we are finished, we all take a swim.

Tomorrow we learn about pain and then all day Monday is lectures by chaplains of varying faith backgrounds. I am loving every minute, and had no idea it would be this spectacular. THANK YOU for helping me to be accepted!!!

I hope you are enjoying your summer as well!

Love,
Colleen

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Looking Back over a Summer Well Spent

By Katherine Sankey

University of Michigan Medical School, Class of 2011

Before entering medical school, I was aware that complex and fascinating issues surrounding the art of medicine would be glossed over or skipped. I know that in order to become a competent and compassionate physician, I need to supplement my education with opportunities to explore, observe and practice subjects such as alternative medicine, global health, nutrition and palliative care. AMSA has a strong history of providing opportunities to learn about such topics not thoroughly addressed in medical education. The End of Life Care Fellowship piqued my interest as an opportunity to enhance my education in salient, difficult, and even taboo topics pertaining to death and dying. As soon as I read the fellowship's introductory questions (Are you comfortable educating the patient and family about the dying process? Would you benefit from more End of Life care training?), I was convinced that in order to develop into the physician I want to be, I need practice. There is a shortage of physicians competent to assist the dying and their families with kindness and expertise. Too often the modern medical establishment treats life and death as a simple dichotomy of success and failure, overlooking the imperative to practice good medicine by helping people die well.

In addition to focusing on the patient as a whole person, I highly value the holistic approach taken in palliative care, which includes a multi-disciplinary team, appreciation of the patient's wishes, and attention to emotional and psychological responses to illness. The psycho-socio-cultural issues addressed at the end of life are those I wish we could address with

most patients. In this respect, palliative care may prove to be a highly fulfilling part of my future practice. Through this fellowship, I wanted to take an active role in gaining new insight and skills not only for my own future, but to share with colleagues confronted with the task of caring for dying patients and their families. By designing an EOL curriculum, I am able to empower other students in exploring complicated ethical and practical issues. Finally, despite our lack of biomedical expertise, first-year medical students can certainly hone the ability to assist, by means of listening and offering moral support, to patients whose concerns are overlooked by the busy medical establishment. Through this fellowship, I supplemented my curriculum at a crucial time when we have little clinical exposure but loads of enthusiasm.

Before the AMSA fellowship, I had never really confronted my own mortality or the reality of aging. Seeing our common fate in the faces and bodies of the many dying people I met gave me a more complete view of our shared life trajectory. I even experienced a shift in my own values by witnessing the true value of family at the end of life, which led me to decide I want to live as near my family as possible in the future. Most importantly, I feel I have gained the tools and information necessary to discuss all treatment options, including comfort care and hospice, with future patients. I am grateful to have witnessed the demedicalization of death, which has been medicalized just as birth has away from the natural process it is. All I have seen in this fellowship has greatly expanded my point of view in a multitude of dimensions.

"AMSA has a strong history of providing opportunities to learn about such topics not thoroughly addressed in medical education."

Plan to Attend AMSA's 59th Annual Convention

Win Back Our Profession

March 12-15, 2009

Hyatt Regency Crystal City, Arlington, VA

March 11, 2009

Pre-Convention Symposium on *Patient Safety and Medical Quality*

Once in a Lifetime Opportunity

By Kenneth Leong, Touro University-California, Class of 2011

The Hospice Patient

A poem by Angela Dawn Thacker

A lifetime behind me.
The Unknown up ahead.
Saying good-bye
To the ones by my bed.

Will I go quickly
Or will I go slow?
Will the journey be
painful?
Where will I go?

So many questions
When life comes to and
end.
Who will be my comfort?
Who will be my friend?

A team of angels
Will carry me home.
With them by my side
My family and I don't feel
so alone.

So thank you Hospice
For the care that you
give.
At the end of my life
You have helped me to
live.

Having served as the primary giver for a dying loved one, I experienced the dreadful realities of our medical system and ever since have been determined to become a physician knowledgeable about the issues surrounding end-of-life. Although medical school teaches a wealth of information, my institution failed to provide comprehensive instruction on EOL issues. The AMSA EOL Fellowship in Florida was a once-in-a-lifetime opportunity, and I was ecstatic when I learned I was amongst the few selected to participate.

For six-weeks, I shadowed several interdisciplinary teams consisting of physicians, nurses, social workers, chaplains and health aides. Not only did I round with the medical team at the inpatient unit, I also visited patients in their homes, and nursing facilities. During these visits, I observed physicians interact with patients, debrided my first stage four decubitus, provided wound care with RNs, and observed the social worker tactfully resolve conflict with the patient's family. This refreshing interdisciplinary approach to medicine is a sharp contrast to what I am exposed to in the typical medical setting, where the disciplines are fragmented, with no communication between one another.

Although managing the patient medically is not an easy task, the psychosocial/spiritual aspect of care is arguably the most complicated component of patient care. Not only is the team to deal with the patient's existential anxieties, they also care for the patient's loved ones—with all the turbulent dynamics that come along with it.

I aim to bring my experience back to Touro University, and establish a curriculum that educates the students about the problems patients face during the last days of their life, and the palliative measures hospice has to offer. My curriculum will take a chronological approach, beginning with case presentations of patients I have seen during my fellowship, followed by a visual presentation of common, invasive medical interventions seen at the hospital (i.e. code, parenteral feeding, delirium). To contrast this, a thorough explanation about hospice will be given and the cases will be used to open a discussion about when curative care is appropriate and when comfort should be the goal in patient care. My hope is that this will excite my peers to enroll in the death and dying elective course we hope to create in the future. Finally, I hope to also encourage peers to be active in the medical community and join the American Academy of Hospice and Palliative Medicine and attend the Annual Assembly in 2009.

Reflecting upon my experience the last several weeks, I realize how much I have learned. Death is a topic I now know I have always feared to dwell upon. It is amongst the most stressful time of a person's life—so distressing that I have seen it splinter a family. After sitting with patients and watching their loved ones valiantly walk down this frightening path, I clearly see that medicine alone is not enough. Because of my time at this fellowship, I now return home with an integrated philosophy of how medicine can work synergistically with other health care disciplines as necessary to care for those at the end-of-life. All students should be exposed to the concepts of hospice. I look forward to returning to my institution for the opportunity to expand my peers' line of thinking towards not just caring for patients when they are acutely ill, but longitudinally as well towards the very end.



Please help us promote the End of Life Fellowship Program for next summer to your colleagues. Visit the website for dates, information and an application.

www.amsa.org/eol/

Defining “Hospice”

By Lawrence Kim, University of California-Irvine, Class of 2011

I never look forward to having to describe hospice care. It is not because I am unfamiliar with it. After six weeks with Vitas, I have gotten a thorough exposure to the work—clinical, physical, emotional—and I am clearly in a better position than most and possibly even many professional health care providers to describe quality end-of-life care. Nevertheless, despite the countless times I have been posed the question of what I am doing in Florida—by strangers, friends, *parents*—it is never an easy answer. Never have I been able to just succinctly say in a sentence or two what hospice is; instead I answer in *paragraphs*, with a parable, or hypothetical situations, references to pop culture—whatever it takes.

I tend to start off: “hospice is a program that delivers palliative care to the terminally ill.” Then, to ward off any misconception of palliative medicine, I define this. Then to ensure that I make it clear that people on hospice do not *choose* death by abstaining from aggressive therapy, I usually end up telling a hypothetical story about someone diagnosed with cancer who could have undergone more chemotherapy, done absolutely nothing, or enrolled in hospice for symptom management and improved quality of life. This way I make sure the audience considers the moral and ethical forces behind answering the “*Rather than what can we do—what should we do?*” question during the course of treating the patient.

Any functional definition of hospice must be vague. How can it not be when the end-of-life goals of each terminally ill patient are subject to subjectivity? What make the concept of hospice so difficult to capture and verbalize are all the intangible qualities that go along with the treatment of *the individual*. At best, when they define hospice, medical dictionaries, the WHO, Merriam-Webster can only *refer* to types of services provided and then maybe offer a sufficiently vague line about how it aims to treat the entire individual—both mind and body. Hospice care is necessarily unique for each patient. And it is the individualized approach that reveals the humanity of the hospice program.

I feel that I value such an individual approach to patient care because it demon-

strates the respect that is due to anyone. After all the rounds and tag-a-longs this summer, I have come to learn that there are subtle qualities to *truly* respecting a patient—something that I am sure many of us struggle with everyday. In medical school and years previous, I have been taught to “listen to the patients” and people use this as a dictation to demonstrate *kindness*. Is this enough? One can be polite and listen, smile and nod. But I feel in this, the hidden aim—to establish a connection with the patient, or, as we usually hear in medical school, to build *rapport*—becomes misrepresented. Rather, I think what is involved in truly respecting a patient is a bona vide *curiosity* in the patient’s life, to notice important things and see and think and figure out the essence of things. The act of listening is a big part of it absolutely, but there is something deeper, more earnest, subconscious, and perhaps, more solemn.

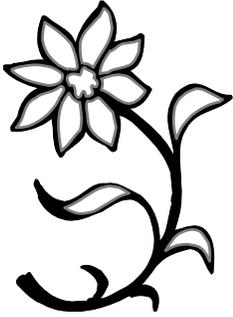
In interviews and conversations, I realize that the discourses are not about me, but about the patients: their story, their ambitions, and their death that they have to deal with. The terminally ill patient owns the conversation. But the connection that I feel we make is more than just about our goals to heal and to be healed; it is a very human and yet spiritual connection with a mutual understanding between us that cannot be established with just words.

Whether I will myself celebrate my dying process by enrolling in hospice after living a full productive life is too soon to tell. I have seen what I have seen both in and outside of this fellowship to know that hospice is not for everyone the same way aggressive therapy is not for everyone. The best thing for me though is that I can equivocally respect and weigh both options. It is important for anyone who plans to die to responsibly and accurately assess what he or she values. Unfortunately for me—and probably for many others—I figure this may take an entire lifetime! But at least I now have a good understanding of my ultimate options and thus the responsibility to help patients get this same advantage.



Helen

By Katie Wang, Case Western Reserve University, Class of 2011



Special events

- *March 12-15, 2009* AMSA's 59th Annual Convention: **Win Back our Profession**, Arlington, VA / Washington, DC
- *March 11, 2009*, AMSA Pre-convention symposium: Patient Safety and Medical Quality
- AMSA Academy provides leadership training opportunities for physicians-in training

www.amsa.org/news/opps

I have long had an interest in aging, sparked by a four-year long volunteer experience as friend to an elderly housebound woman named Helen during and after college. My relationship with Helen developed from assisting with grocery shopping to helping with finances and eventually becoming a caregiver. I became keenly aware of the challenges faced by an older person without adequate financial, familial, and social networks. As I learned how much I enjoy being around older people and dealing with the challenges and complexity of aging, I decided to change careers from the non-profit field and apply to medical school.

In the fall of 2006, at the age of 84, Helen suffered a fall. She was hospitalized until her death five days later. While she was in the hospital, I was the main contact for her doctor because she had no family nearby; although I had previously dealt with the loss of grandparents, this was the first time I played an intimate role at the end of someone's life. It sparked my interest in end of life care, for I realized just how difficult it is for patients and their relatives to get adequate information and to coordinate care.

I applied to the End of Life Education Fellowship because it incorporated the most important aspects of hospice care—teamwork, an interdisciplinary approach, and integration of both clinical work and communication skills. Dying is a difficult topic for both patients and doctors, and in-

corporating end of life education into medical school curriculum goes one step towards eliciting frank, trusting discussions about death and dying.

Yet I learned so much more than I expected. I saw the kind of doctor I want to become. I started to solidify my career goals. I realized that though I may eventually become a hospice doctor, I want to first earn my stripes in the field, whether that is internal medicine, family practice, or a specialty. And I made five new friends!!

We were constantly learning and re-applying new knowledge, whether we were in the classroom, in the hospital, or out visiting patients at home or in nursing homes. Some of the most memorable moments from the six weeks occurred in the informal setting of a leisurely lunch, picking a doctor's brain en route to see another patient, or talking with my roommates about a particularly striking or difficult encounter.

Death and dying may not be an easy topic, but it is important to realize the value that end of life care places on quality at the end of life, comfort, and closure for both the patient and family. Topics related to end of life care are relevant to all future health care practitioners. I was able to learn from experts and fellow students and now look forward to sharing that knowledge with my peers.

Why I Joined the AMSA End-of-Life Fellowship Program

By Angela Dawn Thacker, Pikeville College of Osteopathic Medicine, Class of 2011

The reason I decided to apply for the AMSA End-of-Life (EOL) Fellowship Program was that I wanted to teach other students at my medical school about hospice and palliative care. One of the major goals of the EOL program was to develop a project that would help raise awareness about end-of-life issues at your medical school. At my school, I hope to bring in guest lecturers for the first and second year students. These lectures will cover end-of-life topics such as the mission of hospice and palliative care, how to break bad news to patients and some of the legal and ethical aspects of death and dying. Also for the third and fourth year students, I hope to help set up an elective in hospice and palliative care. This elective will provide a more hands-on approach to understanding the important aspects of caring for the terminally ill. Through both the lectures and the hands-on experience, I hope that the students at my medical school will have a better understanding of Hospice and Palliative Care and will be able to decide for themselves if this is a field that they might want to pursue.

End-of-Life Care Education: From the Ground Up

By Barry M. Kinzbrunner, MD, Chief Medical Officer,
Vitas Innovative Hospice Care

In 1973, a study by Marks and Sacher published in the *Annals of Internal Medicine* (78:173, 1973) demonstrated that physicians-in-training had little knowledge of how to properly manage pain. Recognition of this gap in physician knowledge led to efforts by leaders in the field of pain management to better educate physicians on how patients suffering from uncontrolled pain should be properly managed. Nevertheless, despite these efforts, as well as the development of the hospice movement in the 1980s, two hallmark articles published in the early 1990s showed that physicians continued to struggle when it came to the management of pain.

While these findings were greeted with alarm, no one should have been surprised. After all, the hallmark of medical education is the concept of apprenticeship. Senior attending physicians with the requisite knowledge and experience are given the responsibility of educating the medical students, interns, residents, fellows, and junior attending physicians who will follow them. This allows for effective continuity of quality medical care and physician attitudes from generation to generation which, while intended only for the good, means that if medical misinformation or poor attitudes pervade, then this, too, will be passed on to those that follow. Hence, in the case of pain management, the lack of knowledge and understanding that was found among physicians in 1973, and that was taught unsuccessfully during the 1980s, remained the standard of practice that was passed down to the next generation of physicians practicing in the 1990s.

As seen from the example above, it is often difficult to teach new concepts and behaviors when older ones are already well established. Oftentimes, it is far more effective to take the new information directly to the students, teaching them the new concepts and behaviors before the older ones can become established as the norm. Hence, when AMSA approached Vitas and asked us to participate in its End of Life Fellowship pro-

gram for medical students several years ago, we jumped at the opportunity to provide physician education at the ground level, before young physicians-in-training have learned information and developed behaviors and attitudes that would have to be “unlearned” in order to be able to provide the patients they care for with appropriate end-of-life care.

Over 25 medical students have had the opportunity to spend 6 weeks with Vitas Innovative Hospice Care staff in South Florida during the last four summers. During the 6 week fellowship, the students have been exposed to the basic principles of hospice and palliative medicine through didactic lectures and discussion groups, and have visited patients with hospice physicians and other members of the hospice interdisciplinary team in private homes, adult living facilities, nursing homes, and hospice inpatient units. Based on the students’ feedback, they have had rich and meaningful experiences that have given them the perspective that death is not a failure and that caring for terminally ill patients is as important and rewarding as curing patients (when cure is possible).

What makes the fellowship even more meaningful is that each student is asked to develop an end-of-life care educational project, with the goal being to bring end-of-life care education to their medical school curriculum. So, not only are we educating the students who participate in the Fellowship, we are also reaching additional students in each of the medical schools represented by the participants, further influencing how terminally ill patients will be cared for by these physicians of tomorrow.

Vitas is proud to be a partner with AMSA in the End of Life Care Fellowship, and we look forward to continuing to educate medical students for many years to come.



Class of 2008 EOL Fellows
with Dr. Rozynes