

Transcript Details

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Improving Palliative Care Quality and Honoring Individual Preferences Near the End of Life

Narrator:

Welcome to ReachMD. This episode is one of four specific topics from *Dying in America*, a report by the Institute of Medicine (IOM), a division of the National Academies of Sciences, Engineering, and Medicine. The following program is intended for U.S. health care professionals only.

Dr. Russell:

Welcome to ReachMD. I'm your host, Dr. John Russell. Joining me today is Dr. James Tulsky with the Dana Farber Cancer Institute and Brigham and Women's Hospital in Boston, Massachusetts. In this episode, we are going to discuss palliative care and the importance of understanding exactly what this means. Dr. Tulsky, welcome to the program.

Dr. Tulsky:

Thank you, Dr. Russell. It's a pleasure to be here.

Dr. Russell:

So, doctor, could you tell us a little bit about your participation on this committee and what made you want to be part of this particular topic and why you think it is so important to share it with us?

Dr. Tulsky:

Well, I've been working to enhance the care for people with serious illness and those near the end of life for nearly 25 years and I remember when the last IOM report on this topic was published in 1997, and at that time it had a really profound effect on the field. It led to a greater focus on the needs of dying patients and it also helped spur more education for healthcare providers and the creation of palliative care as a medical specialty. Unfortunately, it's also painfully clear that care for this population remains fractured and inadequate. So, this committee presented an opportunity to revisit these needs, address the professional and the policy issues that would help us seize the opportunities, and overcome the current challenges.

Dr. Russell:

So both physicians and patients have different understanding of what palliative care is. So how did the report define this and what are the implications of care and patient outcomes?

Dr. Tulsky:

Palliative care provides relief from pain and other symptoms. It supports quality of life, and is focused on patients with serious, advanced illness and their families. Palliative care may begin early in the course of treatment for a serious illness, and may be delivered in a number of ways, and across the continuum of healthcare settings including the home, assisted living facilities, nursing homes, long-term acute-care facilities, acute-care hospitals, and outpatient clinics. It encompasses primary palliative care, specialty palliative care, and hospice care. Also, palliative care has been demonstrated, in randomized controlled trials, to improve quality of life, actually increase length of life, and reduce costs.

Dr. Russell:

Dr. Tulsky, will you please share the differences between basic care and secondary care, and why it's so important to patient management and outcomes?

Dr. Tulsky:

Sure. Basic palliative care, which is sometimes also referred to as primary palliative care, which I think is the word I used before, includes the skills and the competencies that ought to be possessed by all physicians who care for seriously ill patients. These include things like basic pain and symptom management, communication skills that enable effective conversations about bad news, prognosis and advance care planning, and some knowledge of hospice and other services that can enhance a patient's quality of life at home. So that's different than secondary palliative care which is provided by palliative care specialists in consultation and is appropriate for addressing difficult pain and symptom management issues that don't respond to initial lines of treatment, and advanced communication challenges that may involve conflict, complex family dynamics, or comprehension issues. Hospice care is also a form of secondary palliative care. The relationship between primary and secondary palliative care is similar to what occurs in physicians' offices every day where primary care physicians manage common problems such as hypertension or diabetes all the time; however, when a patient's blood pressure or blood sugar remains out of control despite aggressive management with the usual medications and treatments, these physicians refer such patients to nephrologists or endocrinologists; so too, for palliative care. So, using these approaches we can ensure the patients receive the right care at the right time in the right place.

Dr. Russell:

So doctor, which patients should we be referring on to palliative care?

Dr. Tulsky:

All people with advanced serious illness should have access to skilled palliative care or, when appropriate, hospice care, in all settings where they receive care, and that would include healthcare facilities, the home, as well as the community.

Dr. Russell:

If you're just tuning in, you're listening to a medical industry feature focusing on 1 of 4 specific topics on Dying in America. I'm your host, Dr. John Russell. I'm joined today by Dr. James Tulsky and we're discussing palliative care as addressed in the "Dying in America" report from the IOM.

So doctor, what do you think are some common misperceptions about palliative care?

Dr. Tulsky:

Unfortunately, there are certainly a few misperceptions out there. Physicians may equate palliative care with end-of-life care and although end-of-life care is a component of what we do as palliative care providers, it's only one piece of the work and we have a lot to offer patients much earlier in the course of illness. Physicians may also be concerned that if they refer a patient to palliative care all that will happen is that the patient will be talked out of receiving disease-directed therapy. This, too, is incorrect. The goal of palliative care is to match patient values and goals with the appropriate treatment. That means that when I learn that a well-informed patient's goals include taking a very aggressive approach, I may be the one advocating for transfer to the intensive care unit. Another fear of palliative care referral is that all we do is sedate uncomfortable patients with morphine. In fact, our specialty is all about taking a new nuanced approach to pain and symptom management and applying a sophisticated understanding of opioids and other drugs to help manage symptoms while promoting awareness and quality of life. The bottom line is that the goal of palliative care is to help patients and their families live as well as possible for as long as possible.

So, Dr. Tulsky, does palliative care lead to a better quality of life for our patients?

Dr. Tulsky:

Palliative care is associated with a higher quality of life including better understanding and communication, access to home care, emotional and spiritual support, well-being and dignity, care at the time of death, and a lighter symptom burden. Some evidence suggests that, on average, palliative care and hospice patients may actually live longer than similarly ill patients who did not receive such care.

Dr. Russell:

So doctor, even though we have a lot of colleagues who deal with diseases that really should be consulting palliative care early, oftentimes it's not as timely as we would like, correct?

Dr. Tulsky:

Unfortunately, that's correct. Although professional guidelines and expert advice increasingly encourage oncologists, cardiologists, and other disease-oriented specialists to counsel patients about palliative care, widespread adoption of timely referral to palliative care appears to still be slow.

Dr. Russell:

Do most health professionals have the skills and competencies that they need to provide basic palliative care?

Dr. Tulsky:

Again, because of the lack of education, health professionals are not always adequately prepared to deliver basic or primary palliative care to patients who are not currently hospitalized or do not require specialty palliative care.

Dr. Russell:

The report indicates that both understanding palliative care and managing patients correctly should be core competencies. Would you please elaborate on this for us?

Dr. Tulsky:

Sure. The IOM report recommends that professional societies and other organizations that establish quality standards, develop standards for clinician-patient communication and advanced-care planning that are measurable, actionable, and evidence based. These standards should be linked to reimbursement, licensing, and credentialing. All clinicians across disciplines and specialties who care for people with advanced serious illness should be competent in basic palliative care including communication skills, interprofessional collaboration, and symptom management. To help get there, educational institutions, credentialing bodies, accrediting boards, state regulatory agencies, and really all healthcare delivery organizations should establish the appropriate training, certification, and/or licensure requirements to strengthen the palliative care knowledge and skills of all clinicians who care for individuals with advanced serious illness or nearing the end of life.

Dr. Russell:

So, when you're looking at what are some of the major stumbling blocks to educating health professionals for palliative care, what are the problems that you see?

Dr. Tulsky:

The establishment of specialty practice in Hospice and Palliative Medicine is a major improvement in the education of health professionals, but three problems remain. First, there is insufficient attention to palliative care in medical and nursing school curricula. Second, there are educational silos that impede the development of interprofessional teams. And finally, there are deficits in equipping physicians with sufficient communication skills.

Dr. Russell:

So, certainly more and more in medicine we're working in teams, is this true in palliative care?

Dr. Tulsky:

Absolutely. Palliative care should encompass access to an interdisciplinary palliative care team including board certified Hospice and Palliative Medicine physicians, nurses, social workers, and chaplains, together with other health professionals as needed. This might include geriatricians, for example. Depending on local resources, access to this team may be onsite via virtual consultation, or by transfer to a setting with these resources and this expertise.

Dr. Russell:

So doctor, based on the report's findings, what can physicians do now to make better use of palliative care in their individual practices?

Dr. Tulsky:

Well, at a very practical level, physicians in practice should consider making palliative care the focus of their next continuing medical education activity. Whether that's attending a regional or a national conference on palliative care, enrolling in a communication skills training workshop, or signing up for an online course, there are many available opportunities out there. Physicians can also learn more about these offerings from national organizations or from their local academic medical center's palliative care program.

Dr. Russell:

Organizationally, how as a country should we go about ensuring that all clinicians have the knowledge, skills, and competencies to provide high quality palliative care?

Dr. Tulsky:

Well, we have a lot of work to do and we need to bring the efforts of lots of different groups together: educational institutions, credentialing bodies, accrediting boards, state regulatory agencies, and healthcare delivery organizations, should all establish the appropriate training, certification, and/or licensure requirements to strengthen the palliative care knowledge and skills of all clinicians who care for individuals with advanced serious illness or nearing the end of life. A few specific examples, all clinicians across disciplines and specialties who care for people with advanced serious illness should be competent in basic palliative care including communication skills, interprofessional collaboration, and symptom management. Educational institutions and professional societies should provide training in palliative care domains throughout the professional's career. Accrediting organizations, such as the ACGME, should require palliative care education and clinical experience in programs for all specialties responsible for managing advanced serious illness and that would be things like oncology or cardiology, but also would include primary care clinicians.

Dr. Russell:

How about different certifying bodies that are in medicine?

Dr. Tulsky:

Absolutely, certifying bodies such as the medical, nursing, and social work specialty boards and health systems should require knowledge, skills, and competency in palliative care.

Dr. Russell:

How about on a state level, a federal level, what are some other things we could do?

Dr. Tulsky:

I think that state regulatory agencies could include education and training in palliative care and licensure requirements for physicians, nurses, chaplains, social workers, and others, who provide healthcare to those nearing the end of life.

Dr. Russell:

So, I assume palliative care is only going to grow as a specialty, so how are we going to get all these specialists in all these different areas to be certified and facile in palliative care?

Dr. Tulsky:

You're absolutely right. The workforce shortage is a huge issue and entities that certify specialty-level healthcare providers should create pathways to certification that increase the number of healthcare professionals who pursue specialty-level palliative care training, and entities such as healthcare delivery organizations, academic medical centers, and teaching hospitals that sponsor specialty-level training positions, should commit the necessary institutional resources to increasing the number of available training positions for specialty-level palliative care.

Dr. Russell:

Dr. Tulsky, I'd like to thank you for sharing the details of the IOM's report on palliative care with our ReachMD listeners.

Narrator:

You have been listening to ReachMD. This program was sponsored by the National Academy of Medicine and focuses on a report by the Institute of Medicine. To listen to this discussion and download the podcast, visit www.ReachMD.com/Dying in America. That's www.ReachMD.com/Dying in America. Thank you for listening.