

AMSA—VITAS End of Life Education Fellowship Program Winter 2010-2011 Happenings

We are happy to report that the AMSA—VITAS End of Life Education Fellowship (EOL) Program will be accepting application for the 2011 program beginning in January 2011. Only six slots exist, so interested AMSA members should apply soon- the deadline is February 28, 2011! Please visit www.amsa.org/eol for all the details.

Should you have any questions about the EOL program, please contact the program manager:

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What better way to understand the impact and importance of this program than hearing from the medical students who have participated in the past. On the following pages are short essays and thoughts written by the 2010 EOL fellows (pictured here) at the end of their six-week program.



Elizabeth Fitzpatrick
M.D. Candidate, University of California San Diego School of Medicine, 2013
EOL Fellow 2010

Life is a series of rites of passages. We come into this world through birth, pass into adulthood, old age, and lastly, we pass out of this world. It is this last rite of passage that is not discussed, dealt with quietly, and ultimately seen as a failure by the medical community. When my mother was diagnosed with terminal cancer, she wanted to celebrate her life and live fully until her death. This was not something we could do from a hospital bed, but something that hospice facilitated. My mother died amidst love, surrounded by her family. It is from this experience that I first learned what a wonderful institution hospice is, and I was inspired to learn more.

The AMSA-VITAS EOL fellowship allowed me to do just that. Not only did I have expert physicians at my disposal to teach me about the medicine and the science of end of life issues, but I was invited into the homes, hearts and lives of the patients. I was able to observe and participate in the profound healing that goes on in hospice care. No, we did not cure cancer or dementia. We instead healed suffering, pain, and discomfort. And not just physical pain! The interdisciplinary team of social workers and chaplains made it a possibility to care for the whole patient and the family.

In the era of managed care and concierge medicine, we no longer have the luxury of time. This summer, I had the time physicians lack. I was able to visit with patients, talk with them when they had no other company, or just sit if they were unable to communicate. I was able to change a patient's day just by turning the air conditioning up, warming up her coffee, and wishing her well. She wished me luck in my endeavor to "change lives", as she said it. At this moment, we were simply two women, talking over coffee and she was not a patient who had just been told that she had inflammation in her brain, most likely from a cancer metastasis.

With this program, I have been able to quell my fears of the "dying patient", and have been able to treat every patient like a person. At the time of death, this most intimate event, this last rite of passage in our earthly lives, I had the privilege to sit by a bedside or hold a hand. I was instantly welcomed into families and trusted with their concerns and fears. All life transitions are met with difficulty: the pain of birth, the responsibility of adulthood, perhaps the loss of autonomy with aging. Hospice is able to smooth out the transition from life to death so that everyone involved can focus on life, and that is great medicine.

Wendy Gardner
M. D. Candidate, Palacky University Faculty of Medicine (Czech Republic), 2013
EOL Fellow 2010

The AMSA EOL Fellowship this summer was a life-altering experience. Although I had worked with hospice for several years in the past as a geriatric social worker, I was not prepared for the challenges presented in the program. Through shadowing six different doctors, and various other members of the interdisciplinary team, I gained a new perspective on what hospice care actually is and does. I would recommend this fellowship to students who want to understand the methods for communicating with patients and their families, but with caution. Death is

personal and requires us to drop protective emotional barriers to attend to the needs of our patients. As with all emotional and spiritual growth, it is not comfortable.

At the start of the program, we were instructed about the Medicare structure and qualifications for treatment. My perception and concern was that this type of care is financially driven. It was very upsetting to me to hear about reimbursement and Medicare guidelines for treatment. I even became angry at one point because I didn't feel it was appropriate for the government to dictate the type of care that can and cannot be provided. Throughout the six weeks, this theme resurfaced and was eloquently addressed by the Medical Directors. The medical field as a whole is a business. To provide the best care for the patients, it is important to understand what their needs and goals are. Sometimes the best alternative costs a lot of out of pocket money, but most of the time it is a matter of spending time. A well directed conversation can improve the outcome far better than any medication or procedure. I saw it with my own eyes and heard it with my own ears. Communication is the key.

The second week, we began our rotation in the inpatient Continuous Care Units. Ironically, we had been taught about the desire of most people to die peacefully at home and the benefits of providing care in the home. It was a stark contrast to that concept. Local hospitals have allocated space to hospice beds, an entire wing in the three locations that we visited this summer. They come to continuous care to manage breathing or pain, to receive transfusions and to adjust medications. At first glance, it appears exactly the same as any other hospital unit, very clinical. There are, however, quiet rooms and a generous family lounge with fresh coffee and other refreshments. The patient rooms are large and decorated in a "homey" fashion, with a sleeper couch to accommodate visitors. Patients are not awakened at the crack of dawn for blood draws and vital signs. Staff members do not wear white coats and rounds are completed at a normal hour. The doctor spends time with the patient and discusses all concerns with family members.

After two weeks of high paced "crisis care", we rotated to the home teams. These visits were the pinnacle of the hospice experience. There is nothing more informative than to see a patient in his or her home environment. Everyone seems more relaxed. But what made these visits special, other than the location, was observing first hand the variations of the truth presented to different disciplines. The example that stands out is when we first went with the chaplain and learned that the patient was anxious and not taking his medications which were prescribed on an as needed basis. He was short of breath and that aggravated the anxiety, or maybe it was the other way around. It was the chaplain that relayed this information to the doctor. When we visited the next day with the doctor, he said he was taking the medications much more than he said to the chaplain. Instead of confronting or reproaching the patient, the doctor gently explained how the shortness of breath would be lessened by the medications and suggested taking it "by the clock". His wife wrote down what the doctor said and agreed his breathing was much better after taking it. That was the second time I witnessed the importance of the team members speaking to each other. Many times, they would just call each other to report a change or concern, but it was the team meetings that really worked to facilitate communication among the disciplines.

Hospice care, as defined by the World Health Organization, is provided by an Interdisciplinary Team made up of physicians, social workers, chaplains, nurses, nursing assistants and team

managers. Each member carries equal importance in the care of the patient and they meet on a regular basis. Fellows are required to attend the team meetings; it is important to see the role that the doctor plays. Rather than the traditional hierarchical scheme, these doctors are dependent on the information presented by the others. The degree of listening shown by the doctors was the same intensity as when the patients themselves were speaking. All team members' input is valued. "We alone cannot treat the patient; it takes a whole team." Within the corporate structure of VITAS, there are intrinsic mechanisms for staff support but the team meetings are the weekly medium. Training scheduled and the chaplain and social worker contribute spiritual, emotional and psycho-social services to the team itself. Team meetings mainly serve to update everyone on the status of the patients, but also for the staff to "debrief". Debriefing is a mandatory self-care concept that is stressed throughout the training and staff education components. It is easy to become detached and calloused as an emotional protective mechanism. Hospice is the very last place where that should be allowed to happen. To facilitate emotional closure, meetings also include a bereavement unit that allows staff to talk about their patients who have died and to share memories. It was uplifting to hear that the staff were emotionally involved with the care of their patients.

Our final rotations were spent in long term care facilities. South Florida is the perfect location for such a study, with a multitude of assisted living facilities and nursing homes. The one that had the most impact on me was a secured dementia unit. It was interesting to observe how the hospice staff interacted seamlessly with the employees of the facility. They worked together in serving meals, social interactions and nursing care. The family members were very pleased with the care and attention given to their loved ones. However, family members did not seem to notice how the hospice staff looked after them as well. Caregiver stress is to be expected and everyone always asked how things were going in the personal life of the visitors, if they had any concerns and if anything else needed to be addressed by the team. Just as much time, if not more, was spent consoling the family members as interacting with the patients.

Overall the EOL fellowship program was informative. The clinical instruction we received was top notch. But what made the biggest impression was the social aspects of end of life care. Obviously, sensitivity is required in treating these patients, but that cannot be taught. Through observation and discussion, we were able to get in touch with the personal barriers that may have prevented us from being present to their emotional and spiritual needs. Our training is to focus on the physical and to "fix" what is wrong through medications and various procedures. But in the end, we merely need to be present and listen. Communication between the doctor and patient, family members and staff is the main element that promotes quality care. One cannot meet the needs of another human being if he or she cannot understand their goals. The only way to do that is to ask and then LISTEN. This program helped me to listen to what the patient wants, through his words and actions, and will make me a better physician regardless of the field in which I choose to practice.

Nilofer Khan Habibullah

M. D. Candidate, American International Medical University (Saint Lucia, West Indies), 2012

EOL Fellow 2010

Six weeks was all it took to give death a whole new meaning. Six weeks of trying our best to help patients hold on to that thin thread of life, six weeks of trials and tribulations we witnessed in a natural element of life called “Death”, six weeks of tearful farewells and joyful cheers for someone who traversed the arduous path of death, six weeks of tackling my own fear of dying, six weeks of negotiating with God to bless me and my loved ones with a ‘humane’ death, six weeks of watching patients die, six weeks of watching them live today....only to see them die tomorrow.

Life is a natural circle and death simply ensures the continuity of that circle. This was my perspective until I joined this program. This program made me realize death is not as simple as a circle, but rather a whole new realm, full of myriad hued dimensions of physical, emotional, mental and social genesis. The AMSA-VITAS End of Life Care Fellowship program taught me most of those realms and issues involved which inevitably changed my original perspective and made me view death as not merely an end, but as a new beginning of the end. It made me appreciate the true meaning of life: which is simply 'living'! Until now, I've just lived weighed down with my own expectations and saw life as merely being successful but now I know better. Death can strike anyone and my time can run out anytime and it is this realization that made me realize that it's imperative to live every moment. Death now seemed fearless. I complete this program with this very thought.

One of my best experiences at the program have been the home visits and appreciating the fact that hospice patient status can take an abrupt turn- having seen a patient scrambling for life under the shadow of the Angel of Death one day, only to see the same patient sit up facing the morning sunshine the next day was overwhelming to me at first. I also had an opportunity to witness some of the best bedside mannerisms I have seen so far, thanks to some of our program physicians. I got to appreciate the fact that brunt of the bitterness of watching a loved one fade away is borne by the immediate family and sometimes even the caregiver and simple empathy can soothe most painful experiences. This made me reinstate my belief in the fact that a good physician is not the one with erudite knowledge but one with a Midas's touch of interpersonal skills and social persona.

One of the main things I would expect the program to improve on would be to provide participants with some emotional support during the painful process of watching people actively dying each day. It was an overwhelming journey; Active learning of bed side know-how and finally culminating with anguish and grief for the ones I watched fade away. Debriefing sessions , in my personal opinion , should incorporate a one-on-one session between the social worker/chaplains and each student. It would not be erroneous to say that this support would not only have benefited me a great deal, but the other fellows as well. Death is seldom a simple subject, thanks to all the heavy emotional baggage it comes with.

Overall, it's been a very enlightening experience and I take this opportunity to thank physicians I worked with and our program coordinators at VITAS and AMSA for helping me view death in a whole new positive way.

I leave Florida with not just a healthy tan but with a new dimension of life and death. I shall also treasure memories of living with two other intellectual participants under the same roof and several other very awesome people I met during the program.

Clayton Milner

M. D. Candidate, University of Kansas School of Medicine, 2013

EOL Fellow 2010

Arriving in South Florida just six weeks ago, I really did not know what was in store for me. The online program description had been succinct but limited, and all I knew of the other students had been gleaned from Facebook pages and a few emails. So it was with some apprehension that I entered the office on the first day, besuited and boisterously expectant. After being told that I needn't keep the coat and tie, as Florida in the summer is quite hot and humid, I was pleased to meet my peers who would turn out to be among the most important part of the program for me. The lectures soon began, and before I knew it we were immersed in the business of Hospice.

The knowledge presented in lectures, including criteria for inclusion, the use of opioid medications, general pathology, and psychosocial and spiritual issues became clearly illustrated when we began rotations. Our rotations included time spent in in-patient units, assisted living facilities, and in patients' own homes. We observed and assisted each member of different Hospice teams, including doctors, team managers, social workers, chaplains, nurses and nurse's aides. I found some of these people to be amazing, some slightly less than amazing, but each doing their job to contribute to the welfare of patients and family.

It has been a draining but rewarding experience. All of the facts, figures, ideas, and philosophies that have been presented to me have contributed to teaching me one very essential lesson. What I have learned is that death is not the important part of the end of life. The important part of the end of a life is the quality of life itself. This includes the quality of life of the terminally ill in their last months, weeks, days, and hours, as well as the quality of the lives of their family and friends both before and after they die. The Hospice model is built around this idea. Nobody can take the difficulty of end of life situations completely away, but with the tools available to each member of the Hospice team, patients and families can be treated as a whole, easing distressing symptoms such as pain and helplessness, and lessening the burden of worries such as funeral arrangements.

Jared Rejeski

M. D. Candidate, Wake Forest University School of Medicine, 2013

EOL Fellow 2010

My participation in the American Medical Student Association's End of Life Fellowship has been a rewarding, revealing, and inspirational experience. The ability to learn from and work with some of the best physicians, nurses, chaplains, and social workers in the nation is something that I could not have anticipated and provided a unique forum for learning. The organization of the program has afforded my fellow classmates and me to learn and hone our skills while remaining relaxed and comfortable during our summer experience. Integration of lectures, debriefings, and clinical experiences brings a unique perspective on the intricacies of caring for patients nearing the end of their lives. Having been educated in the basic requirements for entrance to and services afforded by hospice, I feel that I will be more comfortable advocating for my future patients. The ability to integrate this excellent and important service into my future practice as a physician, I feel, will improve my skills as a healer and allow people to grow even as they are dying.

My experience with the End of Life Fellowship has exceeded my expectations and given me a completely new perspective on the importance of attending to the whole person. Dealing with the physical aspects of care is only part of the picture, and this fellowship has really emphasized the importance of integrating psychosocial and spiritual aspects of a person's life into the everyday practice of medicine. Not only will attending to these aspects of care help us in our diagnosis and treatment, but our patients will surely appreciate the time spent to get to know them as a person. Furthermore, I have gained a new appreciation for the utility of patient education in creating a comfortable atmosphere and the importance of understanding family dynamics when considering a plan of care.

Supplementary to the knowledge I have gained and the skills I have learned through the End of Life Fellowship, I have met several patients who will have a lasting impact on my life and my future practice of medicine. The appreciation that they showed for the care they received through hospice and the outlook they had on the life they had remaining was inspirational and comforting. I know that I will use these experiences to guide me as I meet new patients and that they will help remind me to treat every patient with respect and dignity.

Overall, the End of Life Fellowship has prepared me well to advocate for and care for the dying patient. This experience has helped me better understand and accept the dying process – something that, prior to this fellowship, I did not feel very comfortable with. The exposure to end of life care and guidance and training from the excellent physicians in the program has been invaluable and an experience that would serve any medical student well. Gaining a new perspective on life, death, and the care of dying patients has been surprisingly refreshing and an excellent way to broaden my horizons and hopefully become the best physician that I can be.

Erum Siddiqui
M. D. Candidate, Eastern Virginia Medical School, 2013
EOL Fellow 2010

The last six weeks have changed my understanding of medicine and its context in this country. What originally drew me to this fellowship was placing a personal loss in the context of the medical world, but I gained so much more from this experience than just personal closure.

The clinical pearls that I have picked up this summer were to be expected, I knew I would learn a lot about pathology this summer from Hospice. However, I did not expect to learn as much as I did about the current revolution taking place in health care. On our first day, Dr. Peitzer said to us, "medicine is the easy part." The next few days were spent absorbing ridiculous amounts of pathology and pharmacology, subjects I had not officially had in medical school. I wondered to myself after watching Dr. Pathak make brilliant diagnoses whether I'd ever be smart enough to be such an integrative thinker in the art of diagnoses. As the weeks progressed, Medicare coding and billing came into sight, unattended Ludwig's angina appeared, failing private practices appeared, and through all of these experiences I saw that "medicine really is the easy part." I learned so much this summer about things that are not taught in medical school from individuals who were in my shoes several decades ago, and for that I am incredibly thankful for having been part of this program.

The icing on the cake of dying was becoming comfortable and at peace with a process as mystical as birth. While the obstetricians work on the beginning of life, the hospice teams make the end of life easier for patients and their families. Since end of life care is something that's breezed through during medical school, this fellowship really put it into perspective, and also helped us come to terms with our own mortality, more or less.

I can honestly say that I am walking away from this fellowship with a better trained ear for normal and abnormal heart sounds along with an ear for abnormal pulmonary sounds. I have seen the lacunar infarcts in the actions and behavior of a patient, that my neuroanatomy professor spoke of only a few months ago. Today, I saw my very first stage IV decubitus wound that tunneled into the coccyx region of the lower spine, six weeks ago I didn't even know what a decubitus wound was! While the terminal nature of these patients is sad due to their constellation of symptoms, hospice works to control their symptoms to make those last days more comfortable.