Hospice and Palliative Medicine: What Has Happened to a Beautiful Friendship?

Larry Beresford

Hospice and palliative medicine (HPM) go together. When Balfour Mount, MD, of the Royal Victoria Hospital in Montreal, Quebec, Canada, coined the term *palliative*, it was intended to best represent hospice in the 1970s in the French language. Palliative was thus a synonym for hospice.

The names are still tightly linked—for HPM medical board certification and even in AAHPM's name: the American Academy of Hospice *and* Palliative Medicine. They share a commitment to addressing the symptoms of serious, life-threatening illnesses; providing whole-person care that is respectful of the patient's values and goals for care; and relieving the suffering of serious illness. One could say that palliative care in North America grew out of the hospice philosophy.

In the decades following Dr. Mount's introduction of the word palliative, the field has recognized that excellent team-based care for dying patients would also benefit patients well in advance of the end of life. The term palliative has evolved to reference prehospice patients as well as end-of-life care that is parallel to the care provided by hospice but without the regulations imposed by Medicare.

Team-based palliative care is often provided as a consultative service, originally based in acute hospitals but more recently with increasing deployment to community settings. In an effort to expand palliative care,

marketing and communication strategies have been created to set palliative care apart and exemplify its “upstream” services that can improve patient and family quality of life.

Hospice, by contrast, is tightly defined by the Medicare Hospice Benefit, with a specific regulatory apparatus and a per-diem payment structure, and is reserved for patients who have been medically certified as terminally ill. Originally provided largely in patients’ homes, it also sees patients in nursing facilities or sometimes in hospital-based hospice units.

But shouldn’t these two medical practices, with their shared philosophy of addressing suffering, work hand in hand, helping patients get the care that best meets their needs as their medical condition evolves? In light of the headlines of hospice fraud and concerns for quality in hospice care, coupled with the seemingly less prevalent role for specialized HPM physicians in hospice, some leaders in the field have asked if this beautiful partnership is starting to unravel. Is what could be envisioned in a perfect world as a continuum of care instead becoming two paths that diverge while serving the same population of patients?

Some look to the curriculums of the HPM fellowship programs and wonder what the fellows are taking from their experiences. Are they getting equally career-satisfying experiences in both palliative care and hospice? Or are their training experiences highlighting a divergence in their specialties? Are fellows in their palliative care rotations likely to see and manage patients, in contrast to hospice, where they may predominantly have a shadowing experience or spend time in interdisciplinary team meetings without direct patient management?

Are hospices even available to provide needed placement opportunities for rotations? Are fellowship program faculty familiar enough with hospice care delivery to teach it, and are opportunities available for fellows to make home visits with a hospice doctor to hospice patients as they learn to navigate these distinct care delivery systems?

In particular, it appears that new HPM fellowship graduates are much less likely to choose hospice, less interested in hospice careers, and opting instead for palliative care. A 2017 study by Lupu, et al, found that for the 2015 graduating class of HPM fellows, 72% were working 20 hours or more per week in palliative care, vs 13% working that much in hospice.[1]

Although current data are not available, a somewhat more recent study, published in 2019 by the Academy and the Health Workforce Institute at George Washington University, found that only 8.6 % of the 2018 graduating class reported working in hospice care as their primary practice setting. Similar to the 2015 graduating class, 71.3% of 2018 fellowship graduates spent 20-plus hours per week working in palliative care.[2]

Of course, factors besides personal preference can shape these choices. How many hospices are offering full-time or part-time salaried positions? Do they employ physicians to meet patients face-to-face, either virtually or in person in the patient's homes? Or are their physicians mostly doing administrative tasks such as certifying terminal illness and signing charts, orders, and care plans?

The published surveys found a pronounced preference for palliative care among graduates. Lupu reports that past surveys of HPM graduates did not show a stark difference in salaries between hospice and palliative care. Most fellows reported minimal difficulty finding satisfactory employment positions—although regional variations could pose challenges. But the surveys also found that fellows entered fellowship with a predisposition for palliative medicine, particularly hospital based.

There are an estimated 6,000 Medicare-certified hospices in the United States. A recent issue of this publication explored the problems of over-saturation of hospice programs, with 1,841 of them in Los Angeles County alone—many more agencies than could possibly find specialist physicians and other skilled professionals able to deliver genuine, high-

quality hospice care.[3]

Finding a Career Path Between Hospice and Palliative Medicine

Kaishauna Guidry, MD HMDC, was a latecomer to medicine. She commenced medical school at age 37, after a full life experience with family and community service. She was exposed to palliative care early at Texas A&M University College of Medicine in Bryan, TX, through its humanities-oriented curriculum, followed by clinical electives in her fourth year and as a resident. She took her first job with Companion Hospice, which was later acquired by Bristol Hospice, in 2019.

Although she is involved in teaching HPM fellows, Dr. Guidry did not complete a fellowship herself. “Since there was an abundance of agencies, I was able to jump right into a hospice position out of residency. And I’ve been doing it ever since.” That has included medical director positions in both hospice and palliative medicine.

More recently in 2021, she started a mobile concierge physician service called Mourning Dove Medical. It helps, for example, patients who were enrolled in hospice care but discharged because their condition did not deteriorate fast enough to justify continued enrollment, or patients who are not quite end of life but have lots of medical needs.

Dr. Guidry has written a pocket guide for physicians who don’t know what hospice entails.[4] She also presents a podcast about hospice medical work—“Dr. G at the Heart of Healthcare < https://podcasts.apple.com/us/podcast/dr-g-at-the-heart-of-healthcare/id1680843209> ”—and considers herself an ambassador for the Hospice Medical Director Certification < https://hmdcb.org/> (HMDC) program, which offers a pathway for graduates who didn’t get enough hospice exposure in their training.

“Somewhere along the way, there has been some disconnect between hospice and palliative medicine,” Dr. Guidry related. “It seems like a clinical disconnect—or maybe a social connect. I don’t have the answer to that. I’m still looking for it, but I do what I can to make hospice attractive for HPM fellows, to educate them to see how it’s great work with a flexible lifestyle for the folks who choose to pursue it.”

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A different set of skills is needed when rounding on a hospice patient in a VA medical center vs walking up to a patient’s front door, she explained. “When I’m a guest at someone’s home, asking what they had for breakfast, how they’re feeling today—it’s a casual conversation but I’m getting all the important items checked off my list.” For fellows, she noted, there is just a different comfort level with that.

In fact, for some trainees, HPM fellowship is their first opportunity to visit a patient in their home, an interaction for which their prior medical training in hospitals and clinics did not adequately prepare them.

What Other Factors Impact this Interface?

With approximately 450 existing yearlong HPM fellowship slots and 350 to 400 graduating fellows each year, we know that there are far fewer specialty board-certified doctors than could possibly serve all hospices.[5] Thus most hospices, by necessity, are using physicians without the specialty certification. Some hospices are not investing in

their medical personnel—or perhaps can't find the right personnel—while meeting minimal regulatory requirements using part-time physicians for administrative tasks but not direct clinical contributions to the team.

Other hospices, particularly the larger ones, employ physicians and advanced practice providers full time, deploying them on the road to make regular home visits as part of their jobs. That is in contrast to how specialty palliative care programs are typically staffed. Some home palliative programs don't have physicians, which contributes to a perceived gap between the palliative physician's role in hospitals and clinics vs care in the patient's home.

Hospice care, and the patients it serves, has gotten much more complicated since the Medicare Hospice Benefit was introduced in 1982. More recently, private equity ownership and other financial factors are further impacting the field. But the ongoing debate over for-profit vs nonprofit hospices can divert attention from the real issue of making sure that all hospices meet minimum standards of quality for highly vulnerable patients—including the contributions of physicians with end-of-life expertise.[6]

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Community-based palliative care teams are able to bill for their physician encounters with patients, whether in a clinic, virtually, or through in-person visits, but most of the rest of the team's contributions

go unreimbursed under fee-for-service coverage. Some ask if palliative care physician visits are financially sustainable under fee-for-service models.

Value-based, population health, and accountable care models offer the potential for coverage of the full palliative care team, sometimes giving the palliative care service the freedom to choose who on the team does what in exchange for accepting risk-sharing relationships.

So for new fellowship graduates looking for their first job, this evolving landscape, with its multiple players, multiple models, and questions about sustainability, can be daunting. Are they even empowered to find part-time roles in both settings, or do employers discourage this? Anecdotal reports suggest that some physicians hired for hospital palliative care positions are not allowed to simultaneously accept part-time hospice medical director positions. But many other physicians have contract positions at several sites.

Distinguishing Palliative Care from Hospice

Tarek Mahdi, MD CMD FAAFP, is a family physician with experience since 2000 in both hospice and palliative care. He is now medical director for Palliative Partners, a CHAP-certified, stand-alone outpatient palliative care program comprised of nurses, chaplains, social workers, and physicians in Riverside, CA. It partners on a capitated basis with a Medicaid managed care plan. (California requires coverage of palliative care programs for members of its Medi-Cal managed care plans.)

“We have a current caseload of about 130 palliative care patients, and we’re just touching the tip of the iceberg,” Dr. Mahdi said. Many of these patients still want to receive aggressive treatment. “When we started Palliative Partners, we took pains to distinguish ourselves from hospice. We see palliative care as an outpatient program for patients with chronic diseases.” But he also acknowledged that hospice care plays an

important role in the healthcare system.

Dr. Mahdi said there is a need for more outpatient palliative care but acknowledged that there aren't enough specialist physicians to go around. "We need to get more primary care physicians in the community to recognize the value of these skills. I think there should be more training in primary palliative care. As a family physician, I believe every physician should be experienced in providing palliative care to seriously ill patients. Just merely talking to a seriously ill patient can be palliative. But too often trying to understand the patient's goals of care isn't even addressed."

Aldebra Schroll, MD, a physician with Butte Home Health and Hospice in Chico, CA, where the major hospital in town recently closed down its long-standing hospice and palliative care programs, has a different viewpoint on these issues based on her geographic setting. Participating actively in state and national palliative groups, she hears what's happening in other places. "But I'm in a community that actually is moving away from these services," she said.

"I think we still have a lot of challenges at the most basic level of people even understanding our services. I'm talking about the public, but beyond that, our medical colleagues," Dr. Schroll said. Meanwhile other groups are moving into this arena, some venture capitalist supported and with varying degrees of training and experience.

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That trend was highlighted by a recent GeriPal podcast featuring three representatives of for-profit palliative care providers.[7] In some cases,

approaches dubbed *palliative-lite* emphasize telehealth only, primarily provided by nurses and case managers with little or no physician involvement.

“In hospice and palliative care, we’re struggling with all these competing incentives. Maybe the hospital just wants to open up beds,” Dr. Schroll said. And yet we still hear about the problem of very late referrals to hospice care. “Some of my medical colleagues aren’t even comfortable talking about hospice. And I think they consider death to be a personal failure.”

The Hospice Attending

Laura Hoeksema, MD MPH FAAHPM, medical director for Cleveland Clinic Hospice, sees opportunities to enhance perhaps eroding partnerships in this field. The Cleveland Clinic model is that clinicians in its community-based palliative care program continue to care for their patients after they transition to hospice care.

“Our physicians appreciate the opportunity to continue to care for their patients. And continuity is often highly valued by patients and their families when the patient transitions to hospice care. Having a trusted physician who continues to care for the patient can be comforting. I’d like to see more of this model,” Dr. Hoeksema said.

“We also have some oncologists and primary care providers who act as the hospice attending,” she continued. “Our hospice staff physicians are available to support them when questions arise related to symptom management and end-of life-care.”

Some hospices may be trying to ease the referring physician out of the medical management role, and in some cases access to available reimbursement might be the issue since only one physician can bill as the patient’s attending for hospice care. “We don’t focus so much on the

billable visits. We focus on patients receiving the best possible hospice care we can provide. Patients have a choice about who they want their hospice attending to be. We honor their decision," Dr. Hoeksema said.

Cleveland Clinic Hospice employs six HPM board-certified physicians. They divide their time between hospice and palliative or primary care, she explained. "Physicians care for patients in a palliative care clinic or skilled nursing facility one day. They may see patients virtually the next day and then attend their hospice interdisciplinary team meeting and see patients in their homes the following day."

The Power of Personal Experience

Kevin Dieter, MD HMDC FAAHPM, an associate medical director at Reserve Care, which is a hospice and palliative care provider based in Cleveland, OH, recalled a formative incident early in his career as a family physician more than 3 decades ago. A 93-year-old woman came into his office and said, "'I'm ready to die and I need your help.' I was not ready for that. I was not trained for that."

But he admitted her to the hospital and withdrew all of her life-sustaining medications. She died, slowly but peacefully, over the next 12 days. "I call her my most profound teacher, because she taught me so much every day when I rounded on her."

Shortly thereafter, around 1991, the hospital approached Dr. Dieter and asked him to be the medical director for a new hospice program it was planning. "I had no idea what hospice care really was, but I said yes. And that really opened the door to the rest of my life and my career." Along the way, he learned everything he could, attended national meetings, and in 1999 was grandfathered into his first HPM board certification—thus highlighting the power of personal experience in guiding a career path in this field.

In 2022 Dr. Dieter pursued hospice medical director certification, realizing that the rest of his career was likely going to be primarily hospice focused, after working in both hospice and palliative medicine positions previously. “I wanted to be boarded via HMDC in case I decided not to continue HPM board certification, which I actually decided to pursue anyway.”

Discussions among the founders of AAHPM led to the conclusion that hospice was a wonderful approach to health care, Dr. Dieter related. “It was too bad you had to be dying to get it.” Out of conversations like that emerged the palliative care field in this country—and AAHPM.

“Palliative care took some of the best features of hospice—including the interdisciplinary team, a focus on symptoms, on conversations, and on comfort—and moved them upstream in the course of illness.” Since then, Dr. Dieter has participated in both hospice and palliative care medical positions as well as HPM medical education at Northeast Ohio Medical University.

“There was this sense, early on, that hospice and palliative medicine really understood each other,” he said. But for some physicians, hospice care in the home never seemed like real medicine compared with palliative care in the hospital—done in white medical coats. Some physicians were uncomfortable that hospices did not do all the clinical tests that are normally done in the hospital.

“But we learned early on in hospice care that so much of what we’re doing is not medical—it’s that whole *total pain*, *total person* kind of care, with all the spiritual and psychological and emotional and relational parts of the illness, especially when someone is dying.”

Dr. Dieter said he wondered how the partnership lost its legs somewhere along the way. But he feels hopeful that it can be revitalized. “Maybe this is just the optimist in me, the part that has been at the bedside of so many dying patients, where I learned this concept of a

liminal space. Maybe I'm hoping that our specialty is now in a liminal space, where whatever worked in the past is being left behind because it's not working anymore, but we don't know what the future holds, and it's uncomfortable," he said.

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"I think of that discomfort as a positive thing. Maybe with the younger generation of doctors that are coming out, and wherever our larger healthcare system ends up going, something new can be created out of all this that gets us to a version that makes more sense for the system. I don't even know what that looks like, but I know that the knowledge that our specialty has will never go out of style. It will never not be needed," Dr. Dieter said.

"And the other thing that goes on in this liminal space is what I teach to medical students, residents, and end-of-life fellows. We are the medicine, drawing upon our perfectly imperfect selves coming to the bedside, realizing that medicine doesn't have the answers to everything that happens to people at the end of life. Our field needs to be open to that."

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