The Medical Director as a Member of the Hospice Team

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In this issue of the Journal of the American Medical Directors Association, Vandenberg and Keller\(^1\) provide a literature review illustrating the lack of research related to hospice medical directors and outlining important considerations for those interested in providing medical leadership in a hospice. They cite only 7 articles related to hospice medical direction, and discover only 1 provides data related to the practice. Their article demonstrates that further research into what makes the medical director effective within the structure of the hospice interdisciplinary team is paramount.

The early development of palliative medicine as a distinct discipline parallels the development of the American Medical Directors Association (AMDA). Most of the pioneers advocating for specialty status have been physicians who were either actively serving as hospice medical directors or had previously done so. In the early days following the implementation of the Medicare hospice benefit in 1984,\(^2\) hospice administrators, strapped for resources, called on physician friends, requesting assistance with the hospice, and when starting a program, asking if they would volunteer assistance in serving this special population. As hospices grew, the need for different arrangements arose, medical directors became paid, and ultimately hospices even hired more than one physician.

The Medicare Conditions of Participation (COPs), although recently revised, have not changed the role and qualifications of hospice medical directors. Those regulations state only 1 requirement: they need to be a licensed medical or osteopathic physician.\(^3\) A license to practice medicine is all that is required. There is no mention of certification, continuing education, or palliative care or hospice experience. Although the American Board of Medical Specialties has designated the practice of hospice and palliative medicine as a subspecialty, the hospice regulations do not recognize it. There are no specialty or subspecialty requirements in the regulations; indeed, there is no residency requirement. Technically, a licensed physician of any kind may become a hospice medical director. Ironically, the same is true for nursing and social work; educational credentials are sufficient, experience and certification, while available, is not required.

In an effort to improve hospice medical direction, the experience of AMDA in delineating the role of medical directors in long-term care (LTC) may provide some direction. LTC physicians have vastly different training. Although only 44% of AMDA members have Certified Medical Director (CMD) status, and 43% have Certificates of Added Qualification (CAQ) in geriatrics, AMDA has provided key guidance in the roles and responsibilities of the medical director. This early involvement led to AMDA’s role as a key informant to the Centers for Medicare and Medicaid Services (CMS) for the development of survey F-Tag 501 (medical director).

Much like the development of AMDA, a cadre of individual hospice medical directors recognized the need for collaboration to share best practices in an essentially new field with unique needs. In June of 1988 at the International Hospice Institute meeting in Granby, Colorado, the Academy of Hospice Physicians first met.\(^4\) And again, much like AMDA, the professional organization grew rapidly, increasing from 121 members at the first meeting to 3600 members in 2008. In 1996 the Academy, renamed the American Board of Hospice and Palliative Medicine (ABHPM), offered the first certification exam and awarded 2883 physician certificates in hospice and palliative medicine.\(^5\) Ten years later, the American Board of Medical Specialties (ABMS) approved a subspecialty certification in hospice and palliative medicine, and for the first time, 10 ABMS member boards joined to cosponsor a subspecialty. In 2008, physicians began taking the ABMS certification exam for a CAQ in hospice and palliative medicine.

Despite the achievement of specialty status and the development of fellowship training in palliative medicine leading to full-time palliative care specialists, there remains tremendous diversity in the role of hospice medical directors within the hospice interdisciplinary team, especially outside urban and academic practices. On the one hand, there are hospice medical directors serving the role in a minimal way, attending a team meeting, signing the forms placed in front of them, and leaving. On the opposite end of the spectrum are medical directors who actively lead their hospice teams, leading not only the team meeting, but the admission, certification, and clinical decisions in the care of patients. In both of these cases, the COPs are satisfied; however, the quality of hospice care is not.

Although research in palliative care has grown in recent years,\(^6\) Vandenberg and Keller\(^7\) demonstrate that research related to medical direction in hospice remains sparse. Despite a growing foundation of research related to hospice.
interdisciplinary teams, \cite{7-11} the specifics of the medical director within that structure remain largely unexplored. As Vandenberg and Keller\cite{1} found, neither exploratory nor descriptive studies identifying the role, leadership, or practice of hospice medical direction are evident in the literature. In this regard, hospice medical direction is unique from the rest of the team, as research is being generated related to the practice of hospice nurses,\cite{12-15} social workers,\cite{16-19} and, more recently, chaplains.\cite{7,20}

Identification of hospice medical directors for research is problematic. Although the American Academy of Hospice and Palliative Medicine (AAHPM) has developed a directory for those with ABHPM board certification, not all hospice medical directors belong, and not all physicians with certificates are hospice medical directors. Likewise, AMDA has a directory of those completing CMD training, but again, not all CMDs are medical directors in hospice. The National Hospice and Palliative Care Organization (NHPCO) has a professional membership category for hospice physicians. Professional membership is offered to all staff in NHPCO-member hospices. NHPCO notes that 80% of hospices belong to their organization,\cite{21} but the NHPCO directory of hospice physicians lists just over 600 physician members, an obviously short list when considering the approximately 4600 hospices nationwide.\cite{21} Again, not all physician members of NHPCO are hospice medical directors, as some physicians may practice palliative care outside of hospice.

Hospice medical directors are unique within the team in that their reporting relationship is often unclear. They may or may not receive a formal annual evaluation, and their supervisory relationships within a hospice may not be clear. Another important difference between medical directors and other members of the hospice team is orientation and training. New staff members are given structured orientation not only regarding administrative aspects of hospice but also the clinical aspects of palliative medicine. In contrast, physicians may come into hospice as the only medical director, with no specific orientation, no training, no mentor, and at times no experience with hospice regulations. Training for the medical director may be on the job and accomplished by hospice staff as issues arise and conflicts emerge. The medical director may be a team member who appears once every week or two for a team meeting and thus his or her opportunity for specific hospice training may be minimized; his or her role within the team structure may be diminished as well. To address these training concerns, the AAHPM developed a course on medical direction in 2002, and AMDA members have participated as core faculty. Data from 2002 and 2003 have been presented, but since 2004, 650 physicians have attended the training. Recently, a CD-ROM version has been created to allow physicians to obtain training from their home.\cite{4} Research into the effects of the AAHPM course may be one important area for future work.

One of the difficulties with orienting a hospice medical director is articulating the role. As outlined by Vandenberg and Keller,\cite{1} the required description is in the COPs; however, the lines between the required role and the desired role are not as clear. Although on the surface the AMDA recommendations for medical directors appear appropriate, research is not available regarding effectiveness, and no consensus has been reached by hospice medical directors that these are applicable and appropriate for hospice medical direction.

Now that hospice and palliative medicine has achieved subspecialty status, it seems appropriate that an agenda to strengthen and standardize hospice medical direction align with this recognition. Collaboration among the major associations supporting and educating hospice medical directors (NHPCO, AAHPM, AMDA) could result in important change. Notably, this year a planning group with representatives from both AAHPM and the American Geriatrics Society (AGS) has organized member focus groups at the 2008 national meetings of both organizations. In addition, AAHPM has set aside time for the special interest groups including LTC to present symposia. With intentional collaboration, representatives of these organizations could combine their strengths and current curricula to develop a continuing education program specific to hospice medical direction, drawing on the strengths of each association. NHPCO can lead in educational efforts related to hospice regulations; AAHPM, AGS, and AMDA can lead in clinical practice, including fellowship opportunities; and AMDA can provide an understanding of leadership required in medical direction.

AMDA is in a position to serve as a leader for a consensus project on hospice medical direction. The 1991 AMDA white paper on the role of the medical director in LTC can serve as a model. AMDA’s framework for medical direction in the nursing home (physician leadership, patient care—clinical leadership, quality of care, and education) is an appropriate guide for hospice medical direction.\cite{22} In addition, AMDA’s experience with providing systematic processes for quality improvement, such as the Clinical Practice Guidelines,\cite{23} serves as a good model for national hospice organizations. This is especially timely because the Medicare COPs are formalizing quality improvement requirements. Finally, AMDA’s CMD recertification requirement of specific education hours dedicated to medical direction and management could easily be adapted for hospice medical direction. The goal would be to expand the current AAHPM hospice medical direction course to a longitudinal continuing education program.

Finally, a research agenda on the current state of the practice of hospice medical directors, with the goal of establishing an evidence base for clinical care, team role, and leadership is needed. It is critical that data are collected to describe who hospice medical directors are, what their roles are, what their practice patterns are, and what their educational needs are. Once descriptive research can answer these questions, interventions can be designed to strengthen the practice.

Regardless of the response of other associations supporting hospice medical directors, AMDA should embrace hospice medical directors. There is a tremendous opportunity for AMDA to use its experience in LTC and quality improvement to have an impact on hospice care. With the past experience of consensus building and educational support for physicians, AMDA is perfectly positioned to approach NHPCO and AAHPM for a partnership that will improve care for all patients at the end of life, regardless of the setting.
REFERENCES