Roles of physical therapists, occupational therapists, and physician assistants on the hospice interdisciplinary team

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Roles of Physical Therapists, Occupational Therapists, and Physician Assistants on the Hospice Interdisciplinary Team

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2010
Dedication

I dedicate this scholarly project to my parents who have emphasized the importance of higher education and the quest for knowledge from a very early age. To my father, who taught me to never lose the passion for learning and to strive for nothing less than my personal best. To my mother whose friendship, faith, and unconditional love have seen me through the course of my education.

Also, this scholarly project is dedicated to my husband, for his steadfast practical and emotional support of my journey through physician assistant graduate school. His unyielding patience and daily reminders of what is most important kept my aim on achieving this great goal.

In memory of the late Michael Shelton for his unwavering words of encouragement that still resound in my ears although he is not here to see the completion of my degree.

Finally, I dedicate this scholarly project to all those who pursue a career as a physician assistant to work for the greater good of their patients and believe in the value of continued learning.
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Introduction

Hospice provides palliative care to terminally ill patients, offering emotional, social, and spiritual support to both the patient and their loved ones. Hospice is defined as a model of quality care focused on relieving symptoms and supporting patients with a life expectancy of six months or less with an emphasis is on caring, not curing (Hospice Information, 2010). Palliative care is the medical specialty focused on relief of the pain, symptoms and stress of serious illness with the goal to improve quality of life (Hospice Information, 2010). The key difference between hospice and palliative care is that while hospice is reserved for terminally-ill patients with months to live, palliative care is appropriate at any point in an illness and can be provided at the same time as curative treatment (Hospice Information, 2010).

The beginning of the modern hospice movement has been attributed to Cicely Saunders as the only way to treat the patient as a whole and advocate for the team approach (Saunders, 1978). Today hospice is still accomplished through the joint effort from an interdisciplinary team (Wittenberg-Lyles & Oliver, 2007). Working as an interdependent team allows the hospice care staff to pool their knowledge and skill base in order to provide the best and most effective care to the patient. There usually are not clear divisions between the separate roles of the interdisciplinary team members, but instead, the responsibilities and expectations are blurred and overlap (O'Connor, Fisher, & Guilfoyle, 2006).

The concept of the interdisciplinary team in hospice care was promoted further in 1983 with the federal Medicare hospice benefit requiring hospices to provide an interdisciplinary approach to patient care. Specifically the law required an
interdisciplinary team to include a physician, nurse, social worker, and counselor. (Wittenberg-Lyles, Oliver, Demiris, & Courtney, 2007)

There has been a rising trend in the awareness and utilization of allied health disciplines, such as physical therapy, occupational therapy, and physician assistants in the medical care system in the United States (Frost, 2001). Physical therapy, also known as physiotherapy, is defined as therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by disability, injury, or disease that utilizes therapeutic exercise, physical modalities (such as massage and electrotherapy), assistive devices, and patient education and training (Physical therapy, 2010). Occupational therapy is therapy based on engagement in meaningful activities of daily life (such as self-care skills, education, work, or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning (Occupational therapy, 2010). Physician assistants are specially trained and certified midlevel medical professionals who are certified to provide basic medical services (as the diagnosis and treatment of common ailments and prescribing medications) under the supervision of a licensed physician (Physician assistant, 2010).

Incorporating these disciplines into the hospice interdisciplinary team could provide increased quality of life for the terminally ill patients and their families. These disciplines can provide increased knowledge, skills, and tools to allow patients to retain their sense of independence and dignity longer and teach caregivers to safely and efficiently aide the patient for longer home management (Frost, 2001).
Currently the physician assistant scope of practice does not include hospice care. This scholarly project will explore how physician assistants in particular could be utilized in this area of medicine and evidence will be provided to advocate their value on the hospice care team.

While compiling research for this paper it was found that this subject has not been extensively researched so published material on the roles and advantages of incorporating other team members into hospice and palliative care have not been sufficiently reported. The purpose of this paper is to define the role of the physical therapist, occupational therapist, and physician assistant in the hospice care team and to explore the benefits of including these disciplines into the management of terminally ill patients.
Methods

Information for this scholarly project was accessed through PubMed and CINAHL databases as well as other printed texts. Search terms were recorded to ensure accurate report of them. The literature accessed through the databases was saved in a specified folder on an account within that database for easy retrieval. The documents were also printed and filed in a binder so they could be readily reviewed.

PubMed and CINAHL databases contain articles that can be accessed electronically or in print. PubMed includes over 19 million biomedical articles from MEDLINE and life science journals. CINAHL is a comprehensive database containing nursing and allied health literature.

The research was conducted using the following terms to attempt to access all of the previously published literature relating to my project topic: hospice, hospice care, hospice care/history, hospice interdisciplinary team, care coordination, palliative care, occupational therapy, physical therapy, physician assistant, nurse practitioner, patient care team. Combinations of these terms were also be explored.

Professional organizations for hospice care, occupational therapy, physical therapy, and physician assistants were utilized to gather information. Information was also gathered from the World Health Organization on hospice care. Additionally, there are several peer reviewed journals on hospice and palliative care that were reviewed.

Inclusion criteria for articles in this project included that they provide information on the history and purpose of hospice/palliative care, the traditional medical team members of hospice care and their roles, and the benefits of including other disciplines into the hospice care medical team. The search was limited to only articles written in
English and a priority placed on research articles published in the last ten years to ensure the use of current information. A priority was also placed on literature researched on the United States populations so that the project is based on our nation’s healthcare trends.
History and Evolution of Hospice

The field of medicine is a very dynamic, ever evolving due to the results of continuous research aimed to better serve the world’s people. New guidelines are published, medications and vaccinations are approved, and equipment is introduced on a daily basis. Even though the second half of the 20th century brought us wonderful advancements in medical treatments and technology there was still quite a bit of suffering that was not addressed. (Saunders, 2001)

The current medical model is aimed at making a diagnosis, finding and working towards a cure. However, in some cases there is no possible cure and the end of life is inevitable. Patients that are terminally ill struggle with a stigma that they are the failure of modern medicine that is designed to cure and rehabilitate (Rahman, 2000). This can be a source of struggle for many healthcare providers who they feel that their goal to find a cure or make strides towards improvement is not valid. During medical training, clinicians are taught how to diagnosis an illness and the appropriate progression of treatments recommended by modern medicine. However, there is less emphasis on care when the treatment options have been exhausted or are no longer suitable and the end of life is inevitable. Hospice care is designed to focus on relieving symptoms and supporting patients during their end of life rather than making further attempts to cure their terminal illness (Hospice Information, 2010).

Cicely Saunders is considered the founder of the modern hospice movement (Saunders, 1978). She first proposed her ideas in the late 1950s after careful observation of patients at the end of their lives (Loscalzo, 2008). A decade later,
Elisabeth Kubler-Ross, a psychiatrist in the United States presented her book, *On Death and Dying* (Loscalzo, 2008). This was a groundbreaking introduction that confronted the existing resistance to treating people at the end of life with respect, openness, and honest communication and revolutionized and humanized how dying patients were acknowledged and cared for (Loscalzo, 2008).

The term palliative care was coined by Dr. Balfour Mount, a Canadian surgical oncologist, in 1974 in attempt to evade a negative connotation associated with the word hospice in the French culture (Loscalzo, 2008). A major effort to bring palliative care into mainstream medicine was launched with the support of the Robert Wood Johnson Foundation and George Soros’ Open Society Institute and in 2004 Clinical Practice Guidelines for Quality Palliative Care expanded the focus of palliative care to include not just dying patients, but also patients diagnosed with life-limiting illnesses (Loscalzo, 2008). During the past 10 years, the number of patients receiving hospice services has grown by 162%, which has made hospice the preferred service for terminally ill patients in the United States (Hospice Information, 2010).

**The Interdisciplinary Team**

Hospice provides palliative care for terminally ill patients who desire the services (Lovelady & Sword, 2004). Hospice care is based on a holistic approach to treating the patient as a whole. The management of the dying person’s pain requires attention to the physical, spiritual, financial, and psychosocial needs of the patient and the patient’s family, none of which can be accomplished by a single healthcare provider (Oliver, Wittenberg-Lyles, & Day, 2007). Hospice relies on an interdisciplinary team approach
to effectively address all of the needs of the patient and their loved ones and is essential in providing a good death for the hospice patient (Wittenberg-Lyles & Oliver, 2007).

The World Health Organization’s definition of palliative care includes the need for a team approach (O’Connor, Fisher, & Guilfoyle, 2006). In 1983 the federal Medicare hospice benefit issued a requirement for hospices to provide an interdisciplinary approach to patient care (Wittenberg-Lyles, Oliver, Demiris, & Courtney, 2007). Specifically the law required the interdisciplinary team to include a physician, nurse, social worker, and counselor in order to provide family-focused care and improve communication between the patient, family, and healthcare team (Wittenberg-Lyles, Oliver, Demiris, & Courtney, 2007). There have been a few additions to the hospice healthcare team over the past couple of decades. A typical hospice interdisciplinary team currently consists of a medical director, physician, nurse who also functions as a case manager, social worker, pastoral care worker, and certified nursing assistant (Wittenberg-Lyles, Oliver, Demiris, & Courtney, 2007). Saunders was trained as a social worker, nurse, and physician. She was the embodiment of the interdisciplinary team for the modern hospice movement that she initiated (Oliver, Wittenberg-Lyles, & Day, 2007).

To effectively work together to coordinate the plan of care for the patient, interdisciplinary team members must be able to communicate clearly and have defined leadership from different disciplines (Wittenberg-Lyles & Oliver, 2007). The ultimate goal is for to coordinate “different professional disciplines to pool their training, skills and perspectives in order to provide a comprehensive ‘whole person’ approach to the physical, psychological, and spiritual needs of patients struggling with serious illness,
helping them clarify their goals and values in pursuit of a treatment plan that fits their needs and maximizes their quality of life,” (Meier & Beresford, 2008, pg 677). Team members contribute toward the patient’s care from the perspective of their discipline while at the same time engaging in the team approach working towards a common goal of complete and passionate patient care.

Interdependence develops between team members and individuals when they begin to deviate from the rigid boundaries previously demonstrated by their specific disciplines. This flexibility and bridging of gaps allows the creation of professional activities that were not previously possible without collaboration (Wittenberg-Lyles & Oliver, 2007). In this way, hospice interdisciplinary team meetings can also provide a learning environment for healthcare providers by breaking down the traditional barriers between disciplines (Wittenberg-Lyles & Oliver, 2007).

Planning the care for a patient in hospice requires a discipline-specific assessment of the patient and family by the appropriate team members and then for the findings to be shared (Lovelady & Sword, 2004). Members of an interdisciplinary team do not usually work with distinct divisions between roles, but the responsibilities and expectations are blurred. What one member of the team is responsible for may overlap with the expectations of another team member (O'Connor, Fisher, & Guilfoyle, 2006). Professionals must be confident and secure in their abilities and know their roles in order to know what they can contribute and also what they can rely on in a team approach (O'Connor, Fisher, & Guilfoyle, 2006).

While each profession retains its emphasis on its individual area of expertise, it is the linkage of skills and communication that allows cohesive care to achieve the goal of
providing palliative and passionate care to people so that they may comfortably live the end of their lives with dignity. The problems that arise in interdisciplinary team meetings are commonly due to “turf wars” over areas of disciplines (Wittenberg-Lyles & Oliver, 2007). Therefore it is vital for all team healthcare team members to adopt a collective ownership of the goals while retaining individual responsibilities of decision-making as well as working together to implement the decision that is in the best interest of the patient.

The traditional hospice interdisciplinary team includes physicians, nurses, social workers, pharmacists, clergy, dieticians, and volunteers. Each position holds a specific role and contributes to the team from their education, experience, and collaboration. The case manager, whom is generally a nurse, is responsible for coordinating the care of the ill patient. A physician is typically designated as the team leader in a hospital setting, however, in busy clinics other disciplines have stepped up head of the team. (Rock, 2003)

The use of other disciplines in hospice care is a growing trend; however, little has been published on the use of therapies and potential benefits of physician assistants in this area of healthcare (Frost, 2001). As with all areas of in the medical field, change is inevitable with the new studies and research being done on a daily basis. There is a strong movement in hospice care to continue to strive towards providing better, more complete care for the patient and their loved ones.

The question of why this therapy is necessitated for someone with a life expectancy of less than six months is what brings many to think that therapy as a part of functional recovery process has little purpose at the end of life. It is essential to discuss
how therapy can help to avoid injury, resolve safety hazards, assist with pain relief, develop reassurance, and, most importantly, restore a patient's dignity during the difficulty transition associated with the end of life. Therapy provides the tools for the patient to regain control and be responsible for his or her physical limitations at home and restore a sense of self and dignity. (Frost, 2001)

Physical Therapy in Hospice Care

Physical therapy, also known as physiotherapy, is defined as therapy for the preservation, enhancement, or restoration of movement and physical function impaired or threatened by disability, injury, or disease that utilizes therapeutic exercise, physical modalities, massage, assistive devices, and patient education and training (Physical Therapy, 2010). In hospice care the role of the therapy is based on identifying a patient’s functional loss, estimating the functional potential and then designing and implementing a treatment plan to move forward (Frost, 2001).

The realm of physical therapy involves gross functional mobility, which includes changes in body position and physical states affecting the patient’s ability to change position. These gross functional mobility tasks are typically related to bed mobility, transfers, ambulation or gait, and body mechanics by addressing the limitations that cause these debilities. (Frost, 2001)

Physical therapy focuses on gross functional mobility, also known as transitional movements, which is a combination of the change in body position and the physical states affecting the change in body position. Increased bed mobility for a patient can aid in pain relief and diminish pressure to prevent the formation of pressure sores and ulcers. Physical therapists can work with the patients on rolling from lying on their back
to lying on their right or left side and also teach them positioning for comfort and pressure relief. Another skill that can be taught is bridging, by lifting the pelvis off of the bed. This maneuver requires muscle strength and training exercises, but will enable the patient to assist the caregivers in bathing the patient and changing the bed linens. A transition between supine and sitting and sitting and supine would be the functional mobility component beyond bridging allowing the patient to sit up to eat, change clothes, and enjoy company. (Frost, 2001)

Physical therapists are an integral part of facilitating patient transfers which continues to build upon the skills and exercises previously achieved. This includes teaching the patient and caregivers how to set up for a transfer by positioning the wheelchair next to the bed with the wheels locked, working with the patient to move from sitting to standing and standing to sitting, and how to utilize the pivot or slide technique to move from one location to another. Additionally, the physical therapist coaches the caregivers in how to assist the patient correctly. For the caregivers this provides reassurance that they can successfully assist the patient without injuring themselves or harming the patient. For the patient this allows increased mobility and ability to enjoy activities outside of the bed. (Frost, 2001)

Another concern for patients is the ability to ambulate. Physical therapists introduce and teach patients to use assistive devices such as walkers and canes. They also observe the patient’s gait and foot placement in order to better focus their therapies and help the patient work more efficiently. Body mechanics are a large part of what physical therapists do. They can determine potential physical strain and injury during
activity to the patient, as well as to the person or persons assisting the patient, due to body mechanics or positioning. (Frost, 2001)

Being able to perform these tasks increases a patient’s ability to maintain independence and gain self esteem and dignity. By combining skills and building on the activities in a progressive fashion, the patients can gain the ability to move more freely for longer duration at the end of their lives. This can increase self esteem since the patient may be able to partake in more meaningful activities and retain dignity when the environment may appear to be out of control.

Physical therapy can facilitate a hospice care team by addressing limitations that affect transitional movements such as pain, weakness, range of motion limitations, and shortness of breath (Frost, 2001). These limitations are time consuming for the caregiver and costly for the hospice medical team. By strengthening and teaching more efficient movements this area of therapy can decrease the potential of worker injury during patient care. It can also potentially save money by decreasing pain and the patient’s need to rely on others.

**Occupational Therapy in Hospice Care**

Occupational therapy is based on the engagement in meaningful activities of daily life to enable or encourage patients despite impairments or limitations in physical or mental functioning (Occupational Therapy, 2010). These tasks are referred to as activities of daily living. The goal of occupational therapy in hospice care is to promote patient self-care and home management during the patient’s end of life experience and enable him or her to return to performing valued daily tasks (American Occupational Therapy Association, 2010). Particular attention is paid to the individual components of
a task, such as posture and balance (Frost, 2001). Support of upper extremities is a
technique for energy conservation and avoidance of pain while performing a task.
Positioning is a way to increase a patient’s ability to regain some independence.

Occupational therapy works to increase or preserve a patient’s abilities to care
for himself (Frost, 2001). These activities include bathing, dressing, grooming, toileting,
and feeding themselves. By teaching skills and using modification techniques and
equipment, the occupational therapist can enable a patient to maintain his self care
longer during his hospice care. With retained self care there is also retained self
esteem and pride that will also benefit the patient’s mental and emotional wellbeing.

Transfers are also in the realm of occupational therapy in how they relate to
completing activities of daily living and home management. This pertains to activities
such as transfers to and from a shower or tub so that the patient may bathe himself or
decrease his dependence on a caregiver (Frost, 2001). Equally as important is
transferring to the toilet allowing increased privacy and the use of this amenity rather
than a diaper. These transfers are often a source of concern for home caregivers.
Occupational therapists can teach the caregiver as well as the patient how to
successfully maneuver to minimize the risk of injury to either party.

Occupational therapists assist patients in retrieving objects from the floors,
cupboards, or high shelves, and carrying objects (Frost, 2001). This particular
profession introduces assistive devices such as reachers and pick-up aids and instructs
the patients on how to utilize them safely. Just as exercises are repeated to build
strength, drills are used to increase the patient’s effectiveness of using the tools to
maintain his independence.
Most importantly occupational therapy plays an integral role in a patient’s ability to maintain home management in a safe and conducive environment. The therapists use assistive devices and daily living aids to adapt tasks to the functional level of the patient. Such tools can be used to assist with food preparation, managing faucets, lights, doors, drawers, use of remote controls, telephone, and home appliances. Food management, social management, and money management are also addressed by the occupational therapist. (Frost, 2001)

Additionally, since the terminal illness will inevitably lead to the patient’s decline an occupational therapist plays an integral role in modifying the home for the patient’s safety. Since the many patients will spend prolonged periods of time in bed, particular attention is paid to the bed, bedroom, access to the toilet and shower. Occupational therapists can assist in arranging these facilities to ensure maximum care and comfort during the end of life. (Bye, Llewellyn, & Christl, 2001)

There is some overlap of the roles and blurred boundaries between the disciplines of physical therapists and occupational therapists. Together these professionals can coordinate a strong therapeutic plan for a patient in hospice care. Both physical and occupational therapists can work within the patient’s home to assess the environment. Another similarity between the two disciplines is that both physical therapy and occupational therapy work with the caregivers to train them how to safely assist the patient as his or her condition inevitably continues to decline. While both physical therapy and occupational therapy focus on some of the same functional components they are with different intentions that can be successfully combined to achieve a common goal.
Physician Assistants in Hospice Care

An additional healthcare profession that is underutilized in modern hospice care is that of physician assistants. The physician assistant career is relatively new. It was developed in North Carolina in the mid-1960s as a way to train medical professionals quickly so they could extend the primary healthcare services to areas that previously were underserved (Our History, 2010). A physician assistant is a specially trained and licensed, and in the case of federally employed, credentialed, midlevel medical professional who is proficient to diagnosis and treat medical conditions, formulate management plans, and prescribe medications under the supervision of a licensed physician (Allowing physician assistants to serve medicare hospice patients, 2010).

Physician assistants are knowledgeable of clinical medicine, pathophysiology, diagnostics and therapeutics, and pharmacology. Under the supervision of a physician they are able to conduct comprehensive histories and physical examinations, order laboratory and diagnostic tests, prescribe pharmacologic, nonpharmacologic, and complementary therapies (Our History, 2010).

The profession of physician assistant relies heavily on the relationship between the physician and physician assistant. This coordination of care allows for valuable combination of skills and the ability to extend the practice of the physician by caring for patients under the physician’s supervision. A physician assistant can hold a variety of roles in the hospice interdisciplinary team such as clinical leadership roles, clinical consultants, administrators, educators, and researchers (Meier & Beresford, 2006).

Currently, physician assistants are prohibited from providing hospice care to Medicare beneficiaries who elect to receive the hospice benefit due to the Balanced
Budget Act passed by the 105th Congress in 1997. This project is advocating for the use of physician assistants in hospice care and for their services to be reimbursed as a means to better service the patients during a vulnerable time.

Medicare beneficiaries who routinely see a physician assistant for their full-spectrum medical care are not able to receive hospice care provided by their physician assistant causing a break in the continuity of care. The inability of physician assistants to provide these services causes a delay in care to their patient who is burdened to find another care provider during an already difficult time. (Allowing physician assistants to serve medicare hospice patients, 2010)

A petition has begun to have the language in Medicare legislation changed to correct this deficit. Allowing physician assistants to provide hospice care does not change the crucial relationship between the physician and physician assistant. Importantly, it does not increase the cost of care for Medicare either since physician assistants are reimbursed at 85% of the physician’s reimbursement under Medicare. The key benefits are increased patient access to hospice care and improved continuity of care, especially in medically underserved areas. (Allowing physician assistants to serve medicare hospice patients, 2010)

Through this research, it has been found that there are very few articles published on the subject of physician assistants practicing in the realm of hospice and palliative care available for review. From this it can be deducted that this topic has not been sufficiently addressed. There is still a great deal of research to be conducted and reported on the role and advantages that physician assistants may hold as additional team members in the hospice care setting. Therefore, research regarding the roles of
other similarly operating midlevel practitioners, such as advanced practice nurses, has been used to demonstrate the roles and benefits of physician assistants in the hospice care arena.

**Benefits to the Interdisciplinary Team**

The rationale of the numerous benefits of the implementation of an interdisciplinary team utilized in hospice care is based on evidence gained from interdisciplinary work in general medical practice. These include:

- The development of quality care for patients through the achievement of coordination and collaboration of inputs from different disciplines;
- The development of joint initiatives;
- The achievement of better care plans for the provision of holistic care;
- A higher level of productivity; and
- Increased staff satisfaction resulting in a more effective use of resources (O’Connor, Fisher, & Guilfoyle, 2006).

There are benefits to the hospice care team members as well. The inclusion of more knowledgeable personnel and distinct training of additional professions introduces more perspectives to better influence patient care. Additionally, there is a positive financial impact on the hospice program (Frost, 2001). The physical therapist and occupational therapist professions help to save money by teaching the caregiver and patient techniques to protect them both from injury (Frost, 2001). It also is cost effective in that patients can better care for themselves or be cared for at home for a longer period of their life rather than being cared for in an inpatient facility. The addition of the
physician assistant to the interdisciplinary team is a financial benefit because they bill
for reimbursement at 85%.

**Benefits to the Patient**

There are a multitude of benefits provided by the addition of physical therapy, occupational therapy, and physician assistants to the hospice care team. One of the most understated is emotional power for the patients (Frost, 2001). Losing independence is a source of grief and patients grieve their loss of abilities and previous role in the lives they lead. Therapists and physician assistants cater to patients emotionally charged concerns of being able to retain independence and prolong home management. These additional disciplines can assist patients in their need and desire to be able to do the things and would like to make peace with their death and say goodbye, such as visiting a hometown, writing a letter, going to a family event.

An additional benefit of the medical interdisciplinary team in hospice care that cannot be overlooked is an improvement in patient symptoms. It has been shown that there is an improvement in patients’ insight into their own illness and condition due to more cohesive treatment regimens (O’Connor, Fisher, & Guilfoyle, 2006). Multiple medical disciplines each bring an educated view of the condition at hand from varying perspectives of expertise. Combining these viewpoints with enhanced communication between patients, family and medical team there is increased opportunity for clearer explanation and greater understanding of the particular medical condition.

There has also been report of improvement in patient self-reports of physical pain level, non-pain associated symptoms, perception of quality of life, satisfaction with treatment and communication (O’Connor, Fisher, & Guilfoyle, 2006). Also, patients
report significant improvement in physical symptoms from illness (O’Connor, Fisher, & Guilfoyle, 2006). These improvements are due to better management of the patients symptoms. Since every aspect of a person’s condition is evaluated by multiple medical disciplines and suggestions are made from an array of backgrounds to decide on a treatment plan and goal, the patient is receiving care that is directed at the individual rather than one specific complaint.

Benefits to the Caregivers

Benefits to the caregivers are also achieved from the combination of additional disciplines on the hospice care team (Frost, 2001). It is important to remember that hospice care not only focuses on the patient, but also teaches the family and caregivers techniques so that they can assist their ill loved one to the best of their ability and in a safe manner. Caregivers and family members often feel apprehensive about the responsibility of being a caregiver and their ability to perform the necessary care (Bye, Llewellyn, & Christl, 2001). The addition of other disciplines can increase a caregiver’s confidence and can also assist with the caregiver’s emotional stamina.

Physical therapy.

Physical therapy works with not just the patient, but also the caregiver to instill confidence in patient care and mobility. One of the goals of priority for physical therapy is to work to improve and maintain physical abilities as long as possible allowing the patient to be more self-sufficient. Once a patient’s condition has deteriorated to a level that is no longer conducive to independent self-care, the physical therapist works with the caregiver to teach methods of care that utilize energy conservation and safe transfers to prevent injury to both the patient and the caregiver. In turn, these methods
and reassurance are aimed to educate the caregiver so they may allow the patient to remain in the home longer. (Bye, Llewellyn, & Christl, 2009)

**Occupational therapy.**

The use of occupational therapy to assist the caregiver is much like that of physical therapy. Occupational therapists work to preserve activities of daily living for the patient to allow them to retain independence as long as their illness allows which indirectly assists the caregiver by relieving some of the responsibilities while the patient can perform them himself. These activities include feeding themselves, dressing, toileting, and bathing. A caregiver is also assisted by occupational therapists role in performing home safety visits and modifications. By evaluating the environment in which the caregiver will be working to provide care for the patient, the occupational therapist can make suggestions on how to maximize the effectiveness of the surroundings. (Bye, Llewellyn, & Christl, 2009)

**Physician assistant.**

Since physician assistants work as an extension of the physician’s medical practice they can increase the face time a caregiver is allotted to meet with the medical team. A physician assistant is also made available to answer questions and provide psychological support for the caregiver and the patient. The use of a physician assistants can allow the medical providers to spend more time with the patients and their caregivers allowing for better care plan and management. (Bye, Llewellyn, & Christl, 2009)
Conclusion

Hospice care is based on a holistic approach of treating the patients as a whole being rather than just their illness. The use of an interdisciplinary team has long been used in hospice care to meet the needs of the patients and their loved ones at the end of their lives. The addition of physical therapy, occupational therapy, and physician assistants can be effectively used to benefit the team, the patient, and the caregivers.

There are many achievements acquired by the patients throughout their hospice care from physical therapy, occupational therapy, and the potential role of the physician assistant. Pain levels are reduced from a combined effort of the therapists and physicians assistants. Mobility is improved and made safer from the assistance of physical therapy. Patients are able to remain in homes that are modified for safety and are educated how to perform desired everyday tasks and leisure activities with the interventions by the occupational therapists. (Bye, Llewellyn, & Christl, 2001)

The addition of therapists and physician assistants to the hospice care team also benefit the caregivers of the patient. Caregivers are faced with an immense challenge of tending to a terminally ill patient who is most often a loved one as well. With the support of the therapists and physician assistants the patients can be educated on how to maintain their independence as long as possible (Bye, Llewellyn, & Christl, 2001). When this is no longer possible caregivers are better equipped with knowledge on how to assist the patient in a safe and effective manner, instilling confidence and providing reassurance along the way(Bye, Llewellyn, & Christl, 2009).

The inability for physician assistants to work in hospice care with the standing legislation denies a patient who sees a physician assistant for his primary care the
continuity of care that is desired in the medical field. This project advocates the additional values of physician assistants playing a role on the hospice care team and the need for reimbursement for their services.

Even though there is a growing trend of incorporating additional disciplines into the traditional hospice medical interdisciplinary team very few published articles were found on the subject of therapies and physician assistants working in the realm of hospice and palliative care. This is a topic that needs further attention highlighting the current professionals working in hospice and the assets that have been seen from their inclusion.
References


Abstract

Objective

The roles of physical therapists, occupational therapists, and physician assistants on the hospice interdisciplinary team were examined and defined through a literature review.

Method

Information was accessed through PubMed and CINAHL databases as well as professional organizations for hospice care, occupational therapy, physical therapy, physician assistants, the World Health Organization on hospice care, and several peer reviewed journals on hospice and palliative care.

Results

The addition of these disciplines can provide increased knowledge, skills, and tools enabling patients to retain their sense of independence and dignity longer, teach caregivers to safely and efficiently aide the patient for longer home management, and more cost efficiently manage hospice care.

Conclusion

The use of an interdisciplinary team has long been used in hospice care. The addition of physical therapy, occupational therapy, and physician assistants can be effectively used to benefit the team, the patient, and the caregivers.