The Role of the Hospice Medical Director as Observed in Interdisciplinary Team Case Reviews

Debra Parker Oliver, Ph.D., M.S.W.,[1] Elaine Wittenberg-Lyles, Ph.D.,[2] George Demiris, Ph.D.,[3]
Paul Tatum, M.D.,[1] Kelly Regehr, M.S.,[2] and Stephanie Burt, B.A.[2]

Abstract

Background: The purpose of this study was to observe the roles played by six hospice medical directors from two hospice programs during interdisciplinary team case reviews.
Methods: The study analyzed videotapes of case reviews in two hospice agencies over a two year period. The results indicate that the roles and levels of participation vary. Medical Directors were observed reviewing and assisting with care plans, acting as a liaison with primary physicians, educating staff, consulting with attending physicians, participating in quality assurance activities, and dealing with budget issues.
Results: Medical Directors did not make home visits or assume the role of attending physician during the observation period.
Conclusions: The study demonstrates variance in roles among medical directors and raises new questions for future research.

Introduction

BEGINNING IN 1982 with the initiation of the Hospice Medicare Conditions of Participation (COPs), all U.S. hospice agencies participating in the Medicare program were required to have a designated Medical Director on their staff.[1] As hospices have grown, many now have both medical directors and associate medical directors.[2] With revision of the COPs in 2008, specific regulations relating to these roles have been updated.[3] A recent review of scientific literature found that specific research related to the practice of the hospice medical director is lacking.[4] Regulations specify that hospice medical directors review cases for appropriate admission to hospice, assist team and primary physician with development and approval of a care plan, review and update the plan every 15 days, act as a liaison between the hospice and other health care providers, oversee the education and training of hospice staff, act as a primary physician for those who do not have one, and certify the life expectancy of the patient in consultation with the primary physician.[4] While the regulations offer a list of specific roles, additional responsibilities have been recommended.[4] For example, the American Medical Directors Association (AMDA) suggests medical directors should make

visits to patients, provide leadership in utilization review and quality improvement through chart review, and monitor care delivered by primary physicians.[4] How these regulations and recommendations are implemented within hospice programs has not been evaluated.

The majority of medical directors work only a few hours per month[5] resulting in a relationship with hospice agencies different than other members of the team. Not present on a daily basis they are unable to participate in informal discussions, rarely experience social support so often accorded team members, and unfortunately their absence may mean their skills are not always fully utilized. Additionally, supervision and accountability of medical directors differs from other team members because of their unique relationship with the hospice agency.[2] In a study of medical directors it was found that few hospices provided their physician leaders with any orientation or continuing education.[5] Finally, given time restraints, patients and families rarely, if at all, meet the medical director. The physician member of the team is a unique member; he or she has not seen the patient or caregiver and must rely on the reports of others to guide decision making.

The "core" members of the team are required to participate in the development of the care plan, this includes a physician,

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[1]Department of Family and Community Medicine, University of Missouri, Columbia, Missouri.
[2]Department of Communication Studies, University of North Texas, Denton, Texas.
[3]School of Nursing, University of Washington, Seattle, Washington.
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nurse, social worker, and chaplain or other counselor.[3] Other members may include the bereavement coordinator, volunteer coordinator, on-call nurses, and pharmacists. While roles of team members, including the medical director, are outlined in the COPs, collaboration between team members requires flexibility that results in new roles and collaborative acts which are unique to every team.[6]

An interdisciplinary focus is central to hospice philosophy. Dame Cicely Saunders, founder of the modern hospice movement, serves as a model for interdisciplinary collaboration as she was trained as a nurse, social worker, and as a physician.[7] Teamwork requires attention to the total dying person including physical, social, emotional, and spiritual needs. Various professionals come together on a regular basis to discuss issues related to patients and to develop plans of care. These regular biweekly meetings provide a formal opportunity for collaboration and the systematic review of all cases.

Theoretical Framework

The conceptual framework for this project relies on a model of interdisciplinary collaboration by Laura Bronstein[6] that is based in four theoretical perspectives: a theory of collaboration, services integration, role theory, and ecological systems theory. Interdisciplinary collaboration has been defined as an interpersonal process that leads to the attainment of specific goals that are not achievable by any one team member alone.[8] This implies that collaboration is an active, ongoing, productive, and synergistic process. It requires interdependence among members that leads to the creation of new roles and collaborative acts. Additionally, these roles and acts require flexibility and a collective ownership of goals. Finally, collaboration will result in an ongoing reflection of the process by those actively engaged in it.

Hospice medical directors are responsible for the overall care delivered by this interdisciplinary team. While holding this responsibility they are unique in that they have not personally met the patients or the family and they must rely on the documentation, professional judgment, and communication of the other team members. Yet, this theoretical model suggests that hospice medical directors, as core team members, should actively engage in the process, demonstrate collaboration and exhibit flexibility in their roles and interpersonal communication. It would expect that all team members, including the medical director, would initiate and develop a care plan for patients with outcomes that are unique from what any one team person would develop on their own. The synergistic nature of the model allows roles exhibited by any one discipline to vary between teams and individual members.

Aimed at facilitating and fostering collaborative and holistic end-of-life care, regulations require hospice agencies to hold interdisciplinary team meetings at least every other week. However, recent research has illustrated variation in the number and type of disciplines represented in team meetings.[9] Additionally, it has been shown that meetings are being used for additional agendas such as discussing policy, quality improvement, and staff meetings.[10]

Given the importance of routine interdisciplinary team meetings, as well as the lack of research related to hospice medical direction, the goal of the current study was to assess the role of medical directors in interdisciplinary team meetings during the case reviews of specific hospice patients. This study explored the question, "What roles are exhibited by the Hospice Medical Director as observed in interdisciplinary team case reviews?"

Methods

Videotapes of hospice team case reviews, occurring between 2006 and 2008 were used to ascertain the roles played by hospice medical directors. Each videotape (case review) focused on a single discussion of an individual hospice patient. All case reviews were held in the hospice office. The larger study involved 37 patients with 244 case discussions. The case reviews were recorded as part of a larger study related to hospice teams funded by the National Cancer Institute.[11] The larger study had two phases, a control phase which included traditional hospice team meetings (with only staff present), and an intervention phase, which involved the traditional team members but with caregiver participating. Caregivers were defined as any individual designated by the patient as having the primary responsibility for their care, this included both family members and other acquaintances. The sample involved two hospice programs, each with two separate teams and six different hospice medical directors. The hospices served both rural and urban populations in different areas of the same state. One hospice was a hospital based not-for-profit while the other was a corporate for-profit agency.

Videotapes were first organized by medical director revealing 6 different physicians in the sample, each with a differing number of patients and number of case reviews. Next, the lowest number of patients was determined (4) and an equal number of patients for the remaining physicians were selected. This purposeful sampling resulted in 4 patients for each medical director. We placed all reviews for each of the 24 patients into our database for the analysis. Each case did not have the same number of case reviews. We chose to use an equal number of patients rather than equal number of case reviews to allow the analysis of roles played within a total patient case. This resulted in a sample of 24 patients with a total of 68 case reviews. Although the involvement of caregivers was not a part of the sampling strategy, 25 of the case reviews involved caregivers in the team meeting. The presence of caregivers was only a secondary result of the analyzing the roles of the participating medical directors.

Videotapes were imported into a qualitative software program (QSR NVivo 8, QSR International, Cambridge, MA) for structured content analysis. A coding sheet was developed (Table 1) to review each case. The coding categories were based upon Vandenberg's list of medical director roles[4] and specified definitions were written to ensure consistent interpretation. In addition, medical director involvement with budget or cost issues were included as the monitoring of costs associated with care is an appropriate role. Only medical director talk was coded. For each tape reviewed the coder would circle on the coding sheet "yes" or "no" to indicate the observation of the specific behavior. Tally marks were recorded for each behavior so a total count for each case could be taken. Graduate research assistants (GRAs) in communication studies were trained to code the tapes using the coding sheet. They dually coded 5 meeting tapes with 100% agreement on ratings. Subsequent

TABLE 1. CODING SHEET FOR OBSERVATIONS

Medical Director Coding Sheet

Medical Director: _____   Meeting Date: _____   Patient ID: _____   Phase (circle one): 1   2

TOTAL Length of meeting (min): _____   **TOTAL** MD time (min): _____

Please answer the following in terms of WHAT THE M.D. SAYS (i.e., only looking at M.D. talk)

(1) **Review candidacy for hospice certification/recertification** *Does the patient qualify for hospice?* *Qualifications for hospice/Hospice appropriate*	YES	NO
(2) **Assist team in generating care plan** *Actively contributes to discussion on planning* *Makes changes to medication, discusses psychosocial issues*	YES	NO
(3) **Acting as medical liaison between hospice and attending physician** *Conversation about attending physician by M.D. (not R.N.)*	YES	NO
(4) **Education and training for hospice staff and caregivers**	YES	NO
(5) **Act as primary physician for patients as requested** *Discussion that M.D. is the primary physician* *Any indication that M.D. is the primary*	YES	NO
(6) **Consult with attending physicians as requested** *That M.D. has, will, or does actually talk(ed) to the attending physician*	YES	NO
(7) **Make hospice visits as indicated** *"When I saw her/him"—Indication that MD made visit*	YES	NO
(8) **Participate in quality assurance activities of the hospice** *Policy discussion on "how we should do this" or "how we usually do that"*	YES	NO
(9) **Budget issues** *Any discussion on cost issues*	YES	NO
(10) **Other:** _____		

_____

tapes were then individually coded. Direct quotations of the medical directors were transcribed for easy retrieval of remarks as evidence. Results were reviewed by the total research team for face validity as the team had worked extensively with the videotapes in numerous prior studies.

Results

The study involved the review of the 24 patients with 68 hospice team case reviews by 4 unique teams and 6 different physicians. Secondary to the medical director sampling criteria, caregiver and or patients participated in 25 (36.8%) of the case conferences. The number of case reviews for each medical director in the sample ranged from 5–17. The number of roles observed in any one case ranged from 0–4. Evidence was observed for all of the roles on the coding form with the exception of "acting as the primary physician" and "visiting patients." The talk time and the roles observed varied by medical director.

While the length of time and participation in the reviews varied greatly, the discussions averaged 4.7 minutes (range of 1–12 minutes) and the medical director spoke an average of almost one half minute (range of 0–3.3 minutes), an average

of 9.5% of the team case review time. Analysis of the content of the talk time resulted in the identification of specific roles. In 12 of 24 patients (50%) there was little medical director participation and no evidence the physician played any role in the case review. Table 2 summarizes the observations by physician.

Care planning

The most common observed role was assisting the team with care planning; 52% of the cases had evidence of this behavior. For this project assistance with care planning was defined as an active contribution to discussion on planning and included making changes to medications or discussing psychosocial issues. This role was demonstrated when one medical director (MD2) stated, "He has (name of drug) as a PRN. Is he getting that for any reason do you know? We should check."

Staff education

Evidence was found of medical director participation in the education of hospice staff in 16 (23.5%) of the cases. This project defined staff education as medical director talk which

TABLE 2. SUMMARY OF OBSERVED ROLES BY PHYSICIAN

Role	MD1 n = 17 meetings	MD2 n = 9 meetings	MD3 n = 5 meetings	MD4 n = 18 meetings	MD5 n = 7 meetings	MD6 n = 12 meetings
Review	1	0	0	0	0	0
Assist	14	9	2	3	2	5
Act	2	0	0	0	0	0
Educate	8	4	0	0	1	3
Primary[a]	0	0	0	0	0	0
Consult	2	1	0	0	0	1
Visit[a]	0	0	0	0	0	0
Participate	1	1	0	0	0	0
Budget	1	0	0	0	0	0
Other	2	1	0	0	0	0
Total roles observed	31	16	2	3	3	9
Average Percent MD talk time per meeting	17.82%	57.4%	1.21%	.19%	.59%	5.62%

[a]No evidence of enacting this role was observed in the data.

either provided training or information to other team members. One example of educating team members occurred when the medical director explained:

> If he has a left-sided stroke and he has a subluxation in his shoulder, it could be precipitating and it's possible that putting his shoulder in a sling could help with the subluxation and may reduce the episodes as well. You can tell by examining him, does that shoulder tend to be weak? If he has a lot of space between his acromion and humerous then that would suggest that. (MD1)

Consultation with attending physician

The next most common role observed was consultation with the patient's attending physician; identified in four case reviews (5.6%). In this study, consultation was coded when the medical director suggested they had or would discuss an issue with the designated attending physician. An example of this was found when a medical director said, "I think we ought to recommend that maybe we decrease some of these meds and she might be a little perkier. We can send a note to Dr. (name removed)." (MD6)

Liaison with attending physician

Four other roles were observed once or twice during the case reviews. In two meetings, the medical director acted as a liaison between the team and the attending physician. In this project, the liaison role was coded if the medical director spoke about attending physicians. One example of this was when the medical director stated: "Dr. (name removed) might be able to tone it down on the (medication name) too and that might give her a little more energy. He knows her far better than us, so we'll see what he wants to do". (MD1)

Quality assurance

Another role twice observed was the participation in quality assurance activities. In this analysis, quality assurance was coded when the medical director explored any policy discussion on "how we should do this" or "how we usually do that". One specific instance was when the medical director explained: "On those PRN [medications] we should be saying what it is the PRN is for." (MD 2)

TABLE 3. OBSERVED ROLES IN TEAM MEETINGS

Role	Traditional team n = 43 meetings	Caregiver present n = 25 meetings	Total observed roles
Review	1	0	1
Assist	18	17	35
Act	1	1	2
Educate	9	7	16
Primary	0	0	0
Consult	0	4	4
Visit	0	0	0
Participate	1	1	2
Budget	1	0	1
Total observed roles	31	30	61
Average team time per case	201.65 seconds (3.4 minutes)	433.96 seconds (7.2 minutes)	286 seconds (4.7 minutes)
Average MD time	12.79 seconds	52.40 seconds	27.35 seconds
Average percent talk time	6.34%	12%	9.5%

Appropriateness for hospice

A single instance was observed when a medical director was involved in determining the appropriateness of a patient for hospice. This project coded observations of discussions related to the appropriateness for certification/recertification or discussions related to the terminal prognosis of the patient. In this instance the physician asked, "He certainly sounds appropriate for recertification. What's the date for his recertification?" (MD1)

Budget issues

The final role observed involved budget discussions. Although not cited in the Vandenberg discussion[4] the physician author on this manuscript (P.T.) and all authors considered it to be appropriate. This was coded for any discussion on cost. The example observed in the data set involved the medical director questioning, "Who's responsible for ensuring that the consultants bill the hospice?" (MD1)

Other roles

Finally, there were other roles observed which did not directly fall into the nine pre-identified coding categories. Interestingly, one medical director (MD2) took a predominant leadership role at his hospice, taking the lead in the discussion with caregivers and directing the reporting by staff. This role was not observed with two other medical directors at the same hospice (MD1, 3), indicating a large difference in leadership roles between teams in the same hospice program. None of the other five medical directors in this study chose to provide leadership during team meetings. Additionally, during the videoconference where a caregiver participated, the same medical director (MD2) also provided encouragement to the caregiver. Two final observations found a medical director (MD1) suggesting community resources and expressing concern regarding caregiver driving.

Medical directors in this study exhibited higher participation in meetings when caregivers were participating. The percent of participation time was 6.34% compared to 12% when caregivers were present. Table 3 displays the roles observed with and without the presence of caregivers.

Discussion

The goal of the study was to assess the role of medical directors in interdisciplinary team meetings during the case reviews of specific hospice patients. This study explored the question, "What roles are exhibited by the Hospice Medical Director as observed in interdisciplinary team case reviews?" Analysis of team meetings found that the majority of the roles identified by Vandenberg could be found in observations of team meetings. While there were no indications that the medical directors had made any visits or had assumed the role of primary physician for any patients, it could be the result of the sample selected and should not infer that this is not a role for medical directors. These data indicate that the roles most observed were related to making contributions to plans of care and educating hospice staff.

Since the most common role involves clinical contributions and teaching, it appears important that palliative care knowledge and experience would be a qualification for medical direction. The only requirement in the current regulations is that medical directors be licensed physicians; there are no certifications or specialized credentials suggested in the standards.[3] These data would indicate there is a variance in the roles specific medical directors play. There was definite evidence that some medical directors were much more active than others, however the reasons for this variance are unknown. The effect of specialized training and experience of physicians on team participation on the team is a question that emerges from this study and is worthy of future investigation.

Another research question raised by this study relates to expectations that hospice team members have of medical directors. To what degree do the needs of a specific hospice team or the culture of a specific team influence the role and participation of the medical director? These observations indicate that perhaps team members hold different expectations for some physicians than others and the determinants of these expectations are not clear. As new COPs are implemented and new training emerges from professional associations such as the American Academy of Hospice and Palliative Medicine and National Hospice and Palliative Care Organization, it will be important to evaluate the impact of these changes on team expectations and participation.

It was interesting to note that the involvement of caregivers in team meetings seemed to impact the observed role and amount of talk time of the medical directors. These data would indicate that caregiver presence seems to engage the medical director in the meeting process and thus increase participation. This is consistent with the findings of a separate analysis; one of the medical directors was quoted as stating that the presence of a caregiver helped make him a better physician.[12] Additionally, this separate analysis identified the value of medical director interaction with caregivers when one social worker noted that participation in the team empowered caregivers because they could address the doctor and ask them questions directly.[12]

While enlightening, this study is not without limitations. Findings come from a purposive sample of data collected from a pilot intervention study with a small number of medical directors, thus the findings should not be generalized to other hospices and medical directors. It is possible that there may have unintentionally been something unique about the tapes selected that influenced the medical director's behavior. It is not known how the organizational differences between the hospices may have influenced the observed roles.

These data do provide initial evidence of the roles and activities exhibited by hospice medical directors in interdisciplinary team case reviews. They illustrate a large variance in roles and levels of participation, providing insight for future research questions and potential interventions. Hospice medical directors have the potential to hold influential and helpful roles within hospice teams. Specific expertise in palliative care is necessary for medical directors so they may fully assist with care plan development and staff education. Active participation has the potential to positively impact patient care, staff expertise, and improve the overall delivery of hospice services.

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Address correspondence to:
Debra Parker Oliver, Ph.D., M.S.W.
Department of Family and Community Medicine
School of Social Work
University of Missouri
709 Clark Hall
Columbia, MO 65211

E-mail: oliverdr@missouri.edu