



Colleague to Colleague



Dr. Hank Willner

Dr. Willner is the Chief Medical Director at Holy Cross Home Care and Hospice, and a Clinical Assistant Professor of Family Practice at Georgetown University Medical School. He serves as HFA's Medical Consultant and was interviewed by Lisa McGahey Veglahn, Vice President for Programs at HFA.

What led you into the field of hospice care?

I had been in family practice for over 20 years. I began to realize that when I diagnosed a person with a serious illness, I would often lose track of that patient as he or she pursued treatment; then, I'd often be surprised to get a call from a hospice program that the person was dying. I realized that there was a whole window of suffering that I just wasn't seeing. Around that time, I watched the amazing program, "On Our Own Terms" with Bill Moyers. I was truly in awe of the stories I saw of the doctors who were helping patients at the end of life, and I recognized that there was a clinical experience I was missing. Shortly after that, I attended my first EPEC (Education in Palliative and End-of-Life Care) training, and some of the teachers were the very doctors from the Bill Moyers show.

I then decided to contact a colleague at the local Hospice of the National Capital Area and it happened that they were in need of another physician. I decided then to change career paths and become a hospice physician. Since then, I have been board certified and also been an EPEC Trainer. In addition to serving patients and families, I also enjoy teaching medical students and fellows at Georgetown and Johns Hopkins; in fact, I see great hope for the future of hospice and palliative care in my students.

What are some of the biggest changes you have seen in the field since you have been working in hospice and palliative care?

Based on my work, especially with medical students, I see a growing receptivity to palliative care. And some medical specialties are now embracing the idea that less aggressive treatment can be more beneficial. For instance, I am very impressed with the IOM's "Choosing Wisely" campaign, which looks across many disciplines at five things in that field that are done as "habit" but should be re-examined.

In my community, I still do see some resistance; there is often a delay in referrals to hospice. However, I am encouraged especially by the increased interest I see among patients and families in advance care planning, through projects like "Being Mortal" and The Conversation Project.

What do you see as some of the reasons for delayed referrals to hospice?

I always like to quote Ira Byock— "People are still under the illusion that they might be immortal." When a doctor is asked, "Why did this happen to me?", it might be most realistic to answer, "Why did you think it would not?"

So, one reason for delayed referrals is the failure of both patients and doctors to face mortality. Another issue is that doctors are often in denial about how sick patients may be; there is still a real challenge in making a correct prognosis. And more personally, doctors may feel like failures when they consider hospice for their patients. If they do not see referring to hospice in a positive light, they may feel like they are letting their patients down.

Are there other challenges that you see in educating people about the benefits of hospice and palliative care?

A continuing challenge in this work is to bring clarity to the concept and purpose of palliative care. One basic way to do that is to encourage doctors to be open to asking questions about a person's key goals of care, really learning what that person wants. A common belief shared by many doctors is that patients will always want "everything" done for them, in terms of aggressive medical treatment. But many patients simply believe that all treatments work equally; we as doctors still have a long way to go in educating patients about what treatments do and what they do not do.

Another challenge lies in what still occurs in medical training, although some of that is changing. Young doctors are trained, and may really believe, that their role is to "fix" people. It is a challenge to help them embrace, with full compassion, the fact that some people will not get better.

Some of the barriers to this understanding really does lie with the language. I still hear clinicians talk about "withdrawing treatment" or even "stopping" care prior to a hospice referral. Of course, that is not accurate—good end-of-life care is still "treatment" and much can be done to provide comfort and peace. Hospice care is actually aggressive palliative care. But making that shift, changing that concept, takes a certain maturity.

What have been some of the most rewarding components of your work?

The shift to hospice and palliative care has without a doubt made me a better physician. The work has given me a better understanding of the totality of caring for both the patient and the family. And after all these years, I truly love making home visits. It is a real privilege, to see a snapshot of how people live; it makes for a richer, fuller experience when treating people at the end of life. It has also helped me truly appreciate the wonderful work that a team can provide. Working with social workers, nurses, volunteers, chaplains—it has been a truly rich experience.