

AWARD WINNER

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UNIVERSITY OF CALIFORNIA DAVIS  
HEALTH SYSTEM

*Sacramento, California*





Palliative care is not just a concept in a textbook at University of California Davis Health System (UCDHS): it's a way of life and death. The principles and practices of palliative and hospice care are integral parts of the UCDHS culture — to a degree seldom seen in an academic medical center. The evidence is everywhere: from medical school classes and resident training programs to research projects and clinical trials, day-to-day inpatient and outpatient care, and innovative efforts that reach far beyond the academic campus.

The engine driving this pervasive culture is the West Coast Center for Palliative Education and Research (WCCPER), a cross-departmental, interdisciplinary group of physicians, nurses, social workers, psychologists, and health-services researchers. WCCPER's goal is to develop, test, and communicate best-care solutions that help patients and families cope with life's final stages.

A look at WCCPER's wide-ranging clinical and research endeavors is an object lesson in how to push the field forward and make a difference in the end-of-life experience for patients and families. WCCPER enjoys the special advantage of being led by the highly respected Frederick Meyers, MD, chair of UCDHS's department of Internal Medicine. Meyers has been instrumental in integrating palliative care education into all four years of the curriculum at UC–Davis School of Medicine and in infusing the internal medicine residency program with palliative care precepts for all patients. The school was one of the first in the country to offer a four-week elective course in which medical students worked alongside hospice clinicians. For many, it was their first opportunity to talk to dying patients and their families, to experience the dying process, to focus on the palliation of symptoms caused by advanced disease, and to work as part of an interdisciplinary team.

“A lot of what we do comes down to role modeling,” says Meyers, who also serves as director of UCDHS's hospice — one of the few based in an academic medical center. “We try to demonstrate that palliative care is not separate from good medical care — it's part of good medical care.”

WCCPER has successfully demonstrated the pluses of palliative and hospice care in several previously underserved patient populations. In 1998, the center helped develop the first prison hospice unit in California, at the men's maximum-security facility in Vacaville. The hospice has since become a role model replicated in many states. The program broke even more new ground by training inmates to serve as hospice assistants.

“This is a very meaningful program, for the patients, for us, and for the inmate volunteers,” says John Linder, a clinical social worker. “The hospice assistants provide miraculous care. For many, it's the first time they've really cared for someone vulnerable. They get a view of people that they never had before. For some, it's a chance to make amends. It can be transformational for everyone involved.”

Another underserved population on WCCPER's agenda are people in rural areas. The UC–Davis service area encompasses 26 primarily rural counties. In an effort to enhance end-of-life skills among health care professionals in these areas, WCCPER developed a palliative-care needs assessment and provides side-by-side, “live-in” training by an interdisciplinary team. To reinforce the training, WCCPER taps into UC–Davis's extensive telemedicine network, providing monthly, interactive “telepalliation” consultations that link eight remote sites.

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## INNOVATION HIGHLIGHTS

ACADEMIC MEDICAL CENTER WITH  
PALLIATIVE CARE CULTURE

PALLIATIVE CARE CURRICULUM  
THROUGHOUT MEDICAL EDUCATION

OUTREACH TO UNDERSERVED  
POPULATIONS

Further stretching the boundaries is the Simultaneous Care Project, which introduces palliative care to cancer patients participating in investigational clinical trials. Conventionally, patients enter clinical trials with far-advanced malignancy, and energy is focused on disease-directed therapy, rather than on palliation or end-of-life issues. Palliative and hospice care come only after disease therapy has ended, when patients are close to death and have little opportunity to address end-of-life tasks. The Simultaneous Care Project is an attempt to bring enhanced quality of life to these patients.

“In the past, it’s been an either-or situation: Seriously ill patients have been told they can have a clinical trial or they can go home and focus on quality of life,” says Meyers. “We think that’s not an acceptable choice. Participation in a clinical trial should not be a barrier to effective symptom management or disqualify you from hospice. Why can’t patients have both?”

Initial results of the project indicate that they can, with no adverse affects, and the study has generated widespread interest — not just in the oncology community, but also from programs focused on organ transplants, Alzheimer’s disease, and chronic pulmonary and cardiac disease. WCCPER’s precedent-setting engagement in this area has earned it the role of lead agency for a five-year, multi-site follow-up study under the auspices of the National Cancer Institute.

“Part of the satisfaction of this project has been our ability to show that the clinical and palliative care missions don’t have to be in conflict,” says Meyers. “That’s great news for academic medicine, because people who come to academic centers like ours are often those with the most serious illnesses. Our job must be to combine science and research with empathy and caring.”

The cultural shift is already in evidence, says Joan Blais, program administrator. “Everyone here seems to be getting on board with the notion of integrating palliative care into our customary care routine,” she says. “People get it: They know they’re expected to teach it, practice it, and role model it for others. It’s great to be associated with an organization that’s helping put this approach on the national radar screen.” •