OB GRAMLING, M.D., D.Sc., entered an intensive care room at The University of Vermont Medical Center and approached a patient sitting upright in the hospital bed. The patient’s eyes were closed and a thick bandage covered his chest. A nearby machine hissed loudly, delivering a high flow of oxygen through a tube into the patient’s nostrils.

The man had suffered trauma to his chest and underwent a subsequent surgery. Doctors couldn’t figure out why his lungs still weren’t functioning and feared he might not recover. On an early summer morning, they summoned the palliative care team.
Holly Miller says her gift to UVM highlights the crucial role of palliative medicine at the onset of a serious illness. After watching both of her parents die at home — with little oversight from professionals — Miller grew convinced that people must have the chance to choose the kind of death they want and the care that makes them as comfortable as possible.

“we can’t always be cured, but we can be healed,” she says. “we want to cure everyone, but we can’t. we need to give them some time to find some meaningful days before they die.”

With advances in medicine and technology, americans are living longer with illness, even serious illness — requiring ongoing or repeated periods of palliative care. Meanwhile, the number of specialists in palliative medicine — those who have completed fellowships and dedicated training — isn’t expanding fast enough to keep up with demand. each year, fewer than 300 fellowship slots are available to medical school graduates who want to focus on palliative medicine. Graham says. a 2018 study funded by the american academy of hospice and palliative medicine cited an “acute shortage” of specialists and estimated the gap between expected need and available supply at 6,000 to 18,000 physicians, depending on how much time each devotee to palliative practice. the world health organization projected in 2015 that 40 million people worldwide need palliative care each year, but only 14 percent of those in need receive such treatment.

To offset the shortage, UVM now is working to spread conversation proficiency to more clinicians. Using tools developed by VitalTalk, a nonprofit training organization, 30 palliative care experts at UVM have started courses to learn how to convey their knowledge to others.

“We’re creating our own army of communication coaches,” Graham says.

These coaches will receive certification to teach “Mastering Tough Conversations,” a one-day VitalTalk workshop, every month or so for the next three years, starting this fall, for UVM physicians and others who want to hone their dexterity at dialogue.

medical schools emphasize good patient-doctor relations, but in practice, that can fade into the background as advances in therapeutics push to the forefront, Graham says. “in the modern era of medicine we’ve gotten good at diagnosing and curing disease,” he says. “and because of that, we’ve spent more of our efforts towards those ends — which are important — and less on communication about what to expect and prognosis in case we can’t cure those things.”

These are difficult discussions involving fear, emotional distress and often family conflict. the ability to brush these subjects and get to the crux of a patient’s concerns requires a delicate touch. it’s more than a good bedside manner or inclination to chat.

“there’s skill to this,” Peterson says. “and those skills are developed. they’re not innate.”

VitalTalk brings in “scaffolding” to develop these skills, says Stephen Berns, M.D., a VitalTalk instructor and education director of palliative care at Mount Sinai Beth Israel health system in New York City. the course covers a “talking map” of steps and goals, guidance on word choice and question patterns, and ways to verbally and nonverbally show empathy. if a patient is overwhelmed, the doctor begins talking about treatment options, the patient likely will miss that part of the conversation, Berns says.

“As clinicians, we have things to share, and then the patient has things to share, but we need to create space for each other,” says Berns, who joined the UVM division of Palliative Medicine and Larner College faculty that year. “we don’t know what further treatment efforts.”

Care providers who do this well can make a significant difference for patients. Research indicates that palliative medicine can reduce anxiety and pain, relieve symptoms and improve quality of life and mood. a 2003 study of patients with advanced lung cancer found that those who received early palliative care had less aggressive treatment at the end of their lives but survived longer than those who underwent standard care. Researchers also have quantified a cost benefit to palliative medicine, because it decreases the use of invasive measures that tend to add little benefit and cause discomfort and that patients often choose to decline in their remaining time.

For palliative care specialists, the ability to uplift patients balances the intensity of immersing themselves in someone’s grave and vulnerable experience.

“These things are happening to people even if we’re not involved,” says Lindsay Gagnon, a nurse practitioner in the UVM palliative care division. “And once the efficacy of drugs and other things wanes, there’s always more that we can do to provide care and relieve suffering.”

Holly Miller speaking at the 2017 investiture of Bob Gramling, M.D., D.Sc., as the inaugural Miller Chair in Palliative Medicine.

“we can’t always be cured, but we can be healed,” she says. “we want to cure everyone, but we can’t. we need to give them some time to find some meaningful days before they die.”

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— BOB GRAMLING, M.D., D.SC.
To assess something as complex and dynamic as palliative care at the UVM Medical Center and the Holly or procedure, says Gramling, chief of palliative medicine, “value of serious illness conversations for patient care means treating the patient as a whole, not just the disease.” That way, the healthcare system could measure the value of seriously illness conversations for patient care — the same way it would in drug treatment or procedure, says Gramling, chief of palliative medicine at the UVM Medical Center and the Holly or Bob Miller Chair of Palliative Medicine in the Robert Larner, M.D. College of Medicine.

To assess something as complex and dynamic as a conversation, Gramling solicited the help of Maggie Eppstein, Ph.D., chair of the UVM Department of Computer Science and a founder of the University’s Computation Systems Center, who applies high-level mathematical modeling techniques to real-world challenges, and Donna Rizzo, Ph.D., UVM professor of engineering and computer science, who specializes in machine-learning techniques for machine environments.


How do you gauge the quality of a conversation? Usually, discussions between doctors and hospital staff caring for you? But the culture of medicine has since shifted, says, from a focus on keeping patients alive to a recognition that their hopes and personal wellbeing matters as much. UVM medical leadership now finds itself behind the enhancement of palliative care, Berry adds.

Palliative care at UVM remained a hospital-based program until the creation of the Division of Palliative Medicine in 2007, under the direction of the Serious Illness Care program for Ariadne Labs, founded by renowned physician and writer Atul Gawande and operated jointly by Brigham and Women’s Hospital in Boston and the Harvard TH Chan School of Public Health. But the culture of medicine has since shifted, Berry says, from a focus on keeping patients alive to a recognition that their hopes and personal wellbeing matters as much. UVM medical leadership now finds itself behind the enhancement of palliative care, Berry adds.

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“The point of it is being able to create a tool that would aid in potential training or assessment of quality of conversations in a variety of applications,” even beyond the medical setting, Eppstein says. “So far, I have no way of assessing the quality of conversations in medicine, even though it’s critical to good care, especially to palliative medicine.”

“Moments of connection” are moments of silence. How do you gauge them? In moments of silence, the answers to the questions: “I think we’re ahead of the curve here both because our health financing models are moving to being able to value an incentivized system, and our leaders here at UVM are very attentive to caring well for people in our population,” Gramling says of the teleconsult option. "Sometimes it’s really important for the patient or the family or the provider to hear the perspective of the palliative specialist,” Peterson says, particularly when other clinicians are focused on action and treatment. "We lose bigger picture here,” he says. Earlier this year, when Kate Laud’s mother was diagnosed with liver cancer and told she had just weeks to live, they were in shock, Laud says, Gramling, along with the oncologist and internist, offered a level of care that she never expected and somehow ensured “that my mom could be very comfortable and also live,” she recalls. "For my mom, it really was a spiritual aid,” says, "that really helped her emotionally understand, to be that much less afraid of death, because you’re not going to be in pain.” And the value to her family was immeasurable, she adds, “That was the touch we needed. It humanized the process, and it gave us a great sense of relief.”

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On that early summer morning, Gramling’s visit with the ICU patient kicked off a typically busy day. "As a physician, I love being able to focus on a concept of relieving suffering,” he says. "And to understand, to be that much less afraid of death, because you’re not going to be in pain.” And the value to her family was immeasurable, she adds, “That was the touch we needed. It humanized the process, and it gave us a great sense of relief.”