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<https://doi.org/10.33590/emj/10309888>.

### Q1 What sparked your initial interest in healthcare, and led you to pursue a career focused on rehabilitation and Ehlers–Danlos syndrome (EDS)?

I became interested in healthcare at a very young age. I saw it as the perfect marriage between science, art, and, most importantly, the ability to help improve the lives of others. My earliest exposure was as a hospital volunteer at the age of 13. As time went on, my interest and involvement in healthcare increased. This allowed me to spend time as a junior emergency medicine technician, pharmacy technician, medical assistant, and reproductive health educator on a volunteer trip in Uganda.

My interest in EDS started shortly after I was diagnosed with the syndrome in high school. This is what I attribute to allowing me to find my true passion for healthcare. I was able to see, on a very personal level, what a difference good healthcare can make in the lives of patients.

I chose to focus my career on rehabilitation, because its philosophy is about improving the quality of life of others. I think that, in a lot of cases, society is hyperfocused on curing disease, which is, of course, important; however, I would argue that working with patients to improve their quality of life, even when we cannot 'cure' them, is equally important. Rehabilitation also allows me to spend time treating others with EDS and other hypermobility syndromes, along with various other disorders.

### Q2 As a physician assistant, you are directly exposed to the direct impacts of chronic illnesses when caring for patients. Could you tell us about the benefits of employing a multidisciplinary approach in your field, and how this has impacted patients?

I truly believe that the best outcomes for patients are achieved when a multidisciplinary approach is used. Ideally, you have a team of physicians, occupational therapists, physical therapists, nurses, social workers, pharmacists, and mental health providers, and, if your country has them, providers such as nurse practitioners or physician assistants and associates. This team works together to ensure patients have the best care. Not all facilities have access to this; for example, in my case, I often have to take the time out of my day to contact a patient's other healthcare providers and therapists to discuss their observations and plans. My patients often do best when we have multiple providers providing input regarding treatment plans. Simply put, more minds are better than one.

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With regard to patients with EDS and rehabilitation, I am often referring them to physical therapy, occupational therapy, behavioural therapy to assist with coping and pain management techniques, and working with pharmacists for medication management. All of these different approaches tend to have a synergistic effect together.

**Q3** Regarding your recent publication, 'Multidisciplinary Approach to Treating Chronic Pain in Patients with Ehlers–Danlos Syndrome: Critically Appraised Topic', could you explain what led you to write this piece?

As discussed above, I have a personal tie to EDS. I remember being frustrated at the lack of research and recommendations for the syndrome. Often, I would see papers recommending the use of a multidisciplinary approach in treating the disorder, but there was not a good definition of what a multidisciplinary approach was. I had hoped to be able to come up with a better definition of what a multidisciplinary approach was within this paper. While more research is certainly needed, I will continue to focus my research in this area.

**Q4** What do you believe is the most significant reasoning behind the importance of multidisciplinary care in EDS?

Because the pathology of pain in EDS is not well established, we lack targeted treatment for pain in the disorder. Unfortunately, this can mean that one single treatment may not be effective, and often, it requires the use of various modalities to treat the pain. Because of this, various approaches need to be taken, such as physical therapies, occupational therapies, assistive devices, medications, and cognitive behavioural therapy. These can all be useful, and work best when used in conjunction with one another.

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**Q5** Since publication, how has your research been received, and have you observed implementation of the research within clinical practice?

I believe the research has been well received. I have personally used the research within my own clinical practice. I hope that, as time goes on, more people will devote their time to studying EDS and hypermobility syndromes. There is still so much to learn about the disorders. We truly have only see the tip of the iceberg when it comes to these disorders.

**Q6** Have there been any challenges to the implementation of the multidisciplinary approach in your field, and how have these been overcome?

Time is a large constraint. Healthcare in the USA, as I am sure is the case in many other parts of the world, is strained. Patients often have long waiting times, and providers are often pressured to see people in a short amount of time, due to both financial reasons, and in an effort to reduce waiting times for patients. Having good support staff to assist in decreasing provider burden, to allow them to spend time conversing with other






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providers, and allowing them to spend more time with patients, is huge.

Movement from a hierarchical healthcare system with physicians at the head of the system, to a collaborative one, is already occurring, and I believe it will only improve care. Each specialty and provider has a unique perspective and role. The more easily different providers can communicate, the better patient outcomes will be. Electronic medical records have helped with this, but they are far from perfect. Often, nothing can replace a phone call or, in an ideal world, in-person discussions with other providers.

Access to care is a significant issue. Many of my patients must dictate their care based on insurance coverage and cost. Waiting times and distance to specialists can both be issues to access. In my patients with mobility issues, which is a significant portion of the patients I treat as a rehabilitation provider, leaving the house can be difficult, let alone getting to medical appointments. These are complex issues, which I will not pretend to have all of the answers to.

**Q7 You have a special interest in Restorative Justice in Academic Medicine. Could you explain the mission behind this programme, and its importance in the field of healthcare?**

Restorative Justice in Academic Medicine helps to improve communication and engagement among healthcare providers, students, and

educators to discuss difficult topics. It was developed and modelled after First Nation restorative justice practices. It allows participants to have open discussions, and to brainstorm ways to improve society and our communities in direct ways, instead of alienating others who may not hold the same perspective or opinion about a topic. It allows participants to discuss difficult topics openly and without judgement, and to reach common ground and goals. It is my hope that more medical schools and medical institutions implement restorative justice practices to bring their communities together for the common good. Some examples of discussion topics I have had the privilege to facilitate and partake in have included healthcare and disability, intersex healthcare, and social determinants of health, among many others.

**Q8 Looking to the future, is there a direction you intend to focus your subsequent research efforts in?**

I would love to be able to further expand my research on EDS, and as genetic research improves, there will be more targeted treatments for EDS. The opportunity to partake in clinical research and/or case studies would be very exciting to me. I think right now is such an exciting time to research EDS, given current medical advancements. ●