

Palliative Care Medicine

—A Complete Patient-Centered Package

In a growing specialty where quality of life outweighs quantity, physicians are finding satisfaction and patients' and families' needs are met in a way that shows medicine at its holistic and humanistic best.

When Drew Rosielle, MD, completed medical school and started residency training, he also began “the search for the right specialty—a decision that changed multiple times during his training. During medical school, he found he liked working with hospice patients and helping individuals find quality of life during the final stages of their lives. He also discovered that he enjoyed geriatrics and the greater complexity of care these patients presented. Oncology and the deeper, long-term relationships that were formed with patients also piqued his interest. In the end, he realized that palliative care medicine encompassed all of the attributes that he found attractive in these other specialties. Rosielle, who has now been practicing palliative medicine for about two

years at the Medical College of Wisconsin in Milwaukee, is quite sure he has found the “right fit.”

“In my residency, I never felt rewarded treating individuals for high blood pressure,” he says. “What attracted me to medicine were the humanistic aspects—caring for all aspects of people—not just their disease, but the psychosocial aspects as well. In palliative medicine, you have the opportunity to help people make tough, end-of-life decisions and live the best they can before they die. That’s extremely rewarding.”

The humanistic side of medicine is also what attracted Jennifer Shin, MD, to palliative care medicine. Currently completing a one-year fellowship in palliative medicine at Mount Sinai School of Medicine in New York, Shin plans to follow this with a three-year fellowship in oncology. “I really enjoyed my exposure to oncology because it allows you to develop a relationship with patients and families over time,” says Shin. “But when I really thought about oncology and the model I want to practice when caring for my patients, it was the palliative care model of care. Oncology patients are complex and face many complex medical, physical, psychosocial and emotional decisions.



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Drew Rosielle, MD, a palliative care physician at the Medical College of Milwaukee in Wisconsin, says his specialty is a perfect fit for him. “In palliative medicine, you have the opportunity to help people make tough, end-of-life decisions and live the best they can before they die. That’s extremely rewarding.”

Palliative care addresses all of those things from pain and symptom management to quality of life versus quantity of life.”

Roots and growth

Palliative care refers to the relief of stress and symptoms of illness with the goal of preventing and relieving suffering and ensuring the best possible quality of life for patients and their families rather than preserving life at any cost.

David Weissman, MD, the director of the palliative care medicine program at Froedtert Hospital and a professor of medicine in neoplastic diseases at the Medical College of Wisconsin, was among the pioneers in palliative medicine when he developed the program at Froedtert Hospital in 1993.

An oncologist at the time, Weissman says he and some of his colleagues saw a void in the care being provided to critically ill and dying patients. “The principles of hospice had never been integrated into acute care and academic medicine,” he says. “Initially, winning the respect of other physicians was an upward battle, but once they started seeing the impact of the care provided to their patients by palliative medicine specialists, they began to value and respect our contribution.”

Hospitals today are also recognizing the benefits palliative medicine has to offer. According to a Center to Advance Palliative Care (CAPC) analysis of the latest data released in the 2006 American Hospital Association (AHA) annual survey, the number of palliative

care programs has more than doubled from 2000 to 2006—from 632 to 1,299 programs. “Hospitals are beginning to realize that this is a much more cost-efficient style of practicing medicine than the traditional model,” says Weissman.

Another factor fueling the growth of palliative care medicine is the aging population, members of which are the dominant users of the health care system, according to Diane Meier, MD, the director of CAPC and the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine in New York City. “These individuals often present with one or more serious, chronic, co-morbid illnesses,” says Meier. “This is a much more complex and vulnerable patient population than

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in the past. These are patients who in the past would have died but are now living many years with chronic diseases until they are confronted with an acute crisis. It is clear that the usual care pathways in our hospitals have not been designed with that type of complex, long-stay patient in mind.”

Endorsement from the American Board of Medical Specialties, which recognized hospice and palliative medicine as an official subspecialty in September 2006, has heightened awareness of the specialty and is helping shore up the respect of hospitals, physicians, and health care professionals nationwide. “Its growth has been phenomenal,” says Weissman. “This has been due in part to an extreme number of health care professionals who are seeing this as a part of medicine that has been totally neglected,” he says. “There has been a big push to reclaim this area of medicine among physicians, and many are coming from other careers. Physicians are attracted to the fact that it’s patient-focused

✓ **The number of palliative care programs has more than doubled in the years from 2000 to 2006—from 632 to 1,299 programs.**

and it’s doing what they went to medical school for in the first place.”

Rudolph Keimowitz, MD, a hematologist/oncologist for more than 30 years, was on a path to retirement when he was offered a position at the University of Minnesota Medical Center—Fairview—in Minneapolis to serve as a consultant

in palliative care medicine. “It seemed like the perfect opportunity to use my years of experience in taking care of critically ill patients to care for patients with chronic, complex problems,” says Keimowitz. “Palliative care helps put the illness and the treatment options in perspective. It brings an overall supportive approach that is missing if a patient is being taken care of by just one physician.”

What it is, what it isn’t

A lack of understanding as to what palliative care medicine is has been one of the biggest obstacles impeding its growth. Programs focus on the whole patient rather than just the dis-

The Path to a Palliative Care Specialty

Palliative medicine specialists are in greater demand than ever before.

Despite the fact that palliative medicine postgraduate fellowship training programs have grown substantially over the last few years, the number of hospitals looking to fill positions for new palliative medicine programs is outpacing the number of trained fellows. More than 70 percent of hospitals with 250 or more beds and 55 percent of hospitals with more than 100 beds now have hospital-based palliative programs, according to the Center for the Advancement of Palliative Care Medicine (CAPC).

Current fellowship programs now number 61, according to the American Academy of Hospital and Palliative Medicine (AAHPM). Many of these hospitals also offer short-term preceptorship programs. “Seventy-five percent of teaching hospitals have a clinical palliative program and it is increasingly becoming a

part of residency training,” says Diane Meier, MD, the director of the CAPC and the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine in New York City.

Hospice and palliative medicine is a relatively new and growing specialty that is attracting the attention of both physician fellows and practicing doctors because of its more humanistic, patient-focused style of care. The specialty received additional validation when it was recognized as an official subspecialty in September 2006 by the American Board of Medical Specialties.

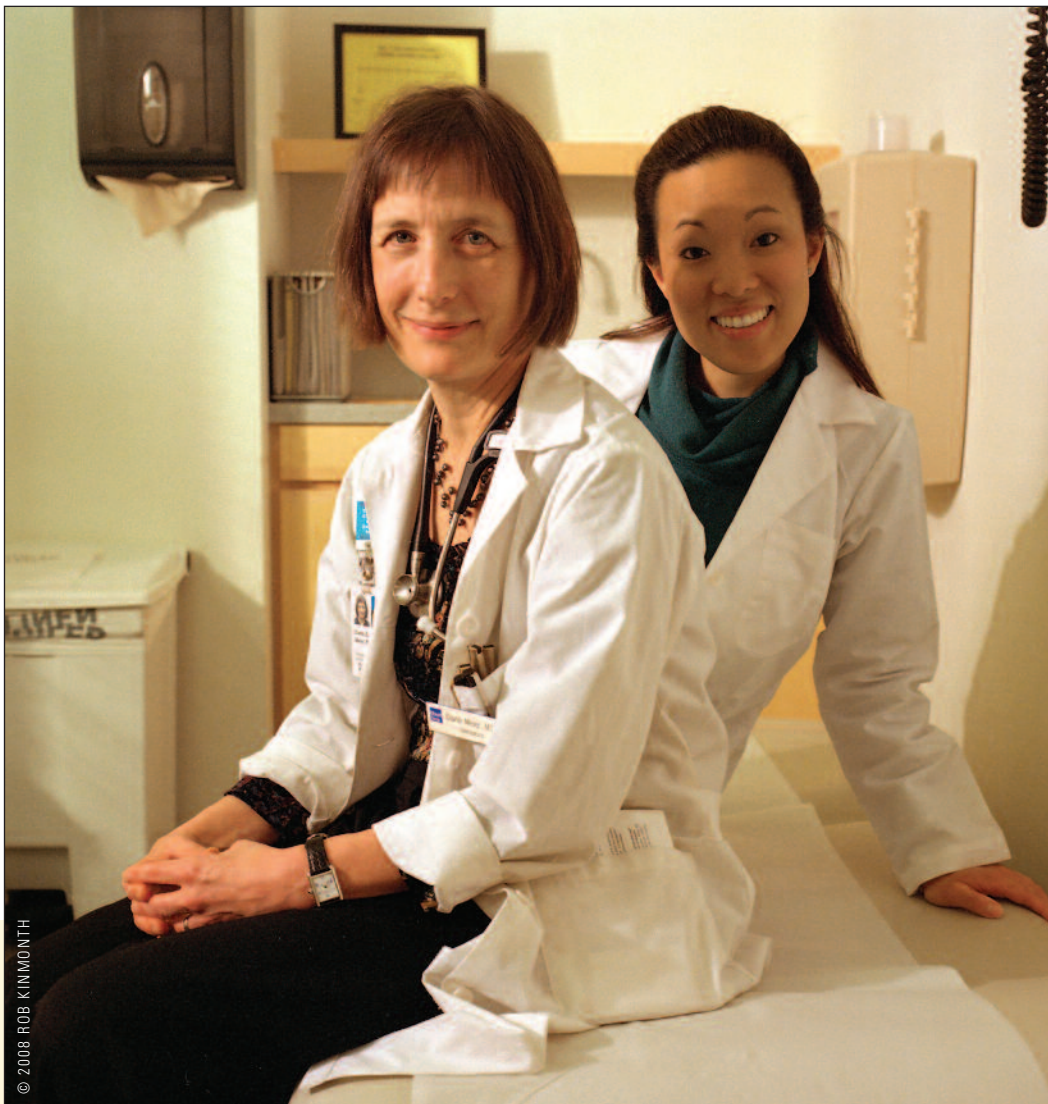
“Many practicing physicians are turning to palliative medicine because they see it as an opportunity to practice medicine as most of us would like to practice medicine,” says Thomas Smith, MD, an oncologist and a palliative care medicine specialist and professor and chair at Massey Cancer Center—Virginia Commonwealth University’s (VCU) division of hematology/oncology in Richmond. “It provides

doctors the opportunity to wrap their arms around the whole patient. It involves medical solving for the condition as well as for the whole person.”

Smith says the the nature of the specialty is challenging. “The environment can be emotionally draining,” he says. “Up to one-third of our admissions result in death.”

Many fellows, says Smith, are combining palliative medicine fellowships with oncology to allow themselves to become better trained at managing pain, treating chronic and complex illnesses, as well as dealing with communication and family dynamics. Starting salaries for palliative medicine physicians average in the \$140,000 to \$180,000 range.

Board certification in hospice and palliative medicine is available via two career paths. Physicians may complete a one-year fellowship program and complete the certification exam. A grandfather clause is being offered to practicing physicians until 2012 to become certified without addition-



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Diane Meier, MD, the director of CAPC and the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine in New York City, left, and Jennifer Shin, MD, currently completing a one-year fellowship in palliative medicine at Mount Sinai School of Medicine. Both find satisfaction in fulfilling terminally ill patients' needs that, until recently, were not fully addressed.

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al fellowship training.

Froedtert Hospital at the Medical College of Wisconsin has been primary player in training health professionals in pain management and palliative care. Weissman, MD, the program director at Froedtert, who is internationally recognized for his work in this field, has been funded by the Robert Wood Johnson Foundation to improve medical residency training through the National Residency End of Life Education Project. Since 1998, nearly 400 residency programs have participated in a one-year curriculum reform project to develop new educational programs in palliative medicine.

For physicians thinking about starting or strengthening a palliative care program at their hospitals, participation in the CAPC's

Palliative Care Leadership program may be the extra boost their programs need.

The CAPC has designated six hospitals as Palliative Care Leadership Centers to help hospitals develop or improve current programs. These facilities include: Froedtert and the Medical College of Wisconsin; Fairview Health Services, Minneapolis, Minnesota; Mount Carmel Health System, Columbus, Ohio; Palliative Care Center of the Bluegrass, Lexington, Kentucky; University of California, San Francisco; and VCU's Massey Cancer Center, Richmond, Virginia. Hospital teams can apply for a two-day training session and an ongoing mentorship. The two-day training session walks each team through the development and implementation of a strategic plan, an organizational model that fits its organization's

needs, staffing plans, how to collect and interpret financial data, and the implementation of marketing strategies to promote and grow its program.

After the on-site training, the staff continues to provide one-on-one mentoring for a full year to assess progress, trouble-shoot, and provide resources.

"Palliative care is a very satisfying aspect of medicine," says Meier. "You are caring for patients and their families who are going through very challenging and profound transitions. You are witness to incredible love and courage on the part of the patients and families, and with training, you are able to relieve what otherwise would have been previously intractable suffering, not only physical, but also emotional, spiritual, and existential suffering. There is no more gratifying feeling than to know as a physician that we met the patient and family where they are, found out what they needed, and mobilized resources to meet their needs." ■

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ease. The specialty encompasses a patient-centered model of care that involves listening and responding to the physical, emotional, and practical needs identified by the patient and family.

Meier says, “It’s whole patient care that entails the patient, family, spiritual needs, finances, community resources, managing the level of pain and other symptoms. It recognizes the need to provide clear, accurate, and repeated information for what the future holds and for what the alternatives are so the decisions are based on the patient’s wishes and are firmly grounded in reality.”

Rosielle agrees. “The priority is not saving lives, or even prolonging lives,” he says. “It’s about helping patients live the best they can before they die.”

Palliative care also goes beyond the doors of the hospital. It ensures that patients are not abandoned once they go home but have the resources they need to continue care at home. According to Meier, “Our job is to make sure the discharge is safe and that the patient and family have not only the knowledge but the professional support they need so they don’t fail at home.”

While palliative care and hospice overlap in their patient-centered philosophies of care, they are different in that palliative care is offered based on need regardless of how long a patient may have to live, whereas hospice care is targeted to people with a limited prognosis. Hospice is focused on terminally ill patients who are no longer seeking curative therapies and who have a life expectancy of six months or less. Palliative care, on the other hand, is provided at any time during a person’s illness, often from the time of diagnosis. In addition, palliative care is frequently delivered at the same time as curative and life-prolonging treatments.

Palliative care refers to the relief of stress and symptoms of illness with the goal of preventing and relieving suffering and ensuring the best possible quality of life for patients and their families rather than preserving life at any cost.

The type of patients seen varies considerably. Some individuals may be in the last month of life, while others may be in the early course of their diseases. Weissman says about half of his patients consist of cancer patients while the remaining half are chronically ill patients with diseases that range from dementia or stroke to Alzheimer’s or heart failure.

Changing the misconception that palliative medicine is merely comfort care has been another challenge facing the specialty. Weissman says that palliative medicine requires a specific set of skill sets that are not taught to the same degree in other specialties. These include sophisticated pain and symptom management, well-honed communication skills and in-depth knowledge about the continuum of care outside the hospital. While some of these skills overlap with geriatrics, oncology or critical care, the additional knowledge of palliative care focuses on the combined needs of patients with serious, complex illnesses and management of complex family dynamics, says Weissman, who practiced as an oncologist for 13 years before becoming a palliative medicine specialist, “What I learned from my oncology training would prepare me very little for what I am doing today.”

The financial issues

Hospitals are considering palliative medicine among the solutions to the fi-

nancial challenges they face in an increasingly competitive health care market. Meier says, “The public’s perception of hospital quality of care is appalling. Every study that has ever looked at it has found an enormous dissatisfaction (among patients) with a number of issues of hospital care, including untreated pain and other symptoms and a lack of communication from physicians.” As hospitals compete to maintain their market share, palliative care medicine is one option that addresses many of these issues, Meier says.

Another issue motivating hospitals is the enormous pressure to reduce length of stay. Palliative medicine has been shown to reduce costs and length of stay for patients near the end of their lives by providing more appropriate care at this stage. While the main goal of palliative care has always been to provide optimal care, a study published in the October 2003 issue of the *Journal of Palliative Medicine*, found that total cost of hospital care can be reduced by almost half for those dying in the hospital. The study revealed that addressing patient and family concerns, and determining what is medically possible (and desirable for the patient and family) allows the health care team to deliver more appropriate care. Many intensive and expensive interventions are often used for dying patients who aren’t treated in the palliative care model, of-

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ten causing unnecessary, additional stress and suffering without significantly influencing the course of a patient's illness, says the lead author of the study, Thomas Smith, MD, an oncologist and palliative care medicine specialist and the chair of Massey Cancer Center—Virginia Commonwealth University's (VCU) division of hematology/oncology. Smith says VCU, which offers both a palliative medicine consulting service as well as a dedicated palliative care unit, says the service provides great symptom management and also reduces costs by transferring patients from high-cost settings to the more appropriate inpatient palliative care unit. This "cost avoidance" translates into more than \$1 million in savings annually at VCU. "The type of care delivered changes a lot once we have talked to the patient and family about the goals of care," says Smith. "It often shifts from a lot of invasive tests to relieving symptoms so the patient can go home."

The practice of palliative care

There are two primary career paths in palliative care medicine. The first of these involves a focus on home visits and hospice administrative work. The newer palliative care model involves a higher tempo, hospital-based setting in which the palliative care physician works in an acute care hospital environment and provides a consultative service to referring physicians. At smaller, community hospitals, it is more common for the palliative care physician to assume care of the patient. Many doctors are practicing a combination of both models, according to Weissman.

In large teaching hospitals, palliative care is usually provided as a consultation service staffed by a multi-discipli-

nary team that includes physicians, nurses, and social workers. Chaplains, massage therapists, pharmacists, nutritionists, and others might also be a part of the team. The palliative care team helps ease case management burdens on primary care physicians and staff and provides assistance with care coordination and time-intensive patient-family communication. As the specialty grows, some hospitals are developing a dedicated unit with specialist nurses and doctors to care for patients who need the more intensive care. Dedicated palliative care units often include space for families to afford them more privacy for meetings, meals, and rest.

The palliative care team at Froedtert in Milwaukee acts as a consultative service that consists of palliative care trained physicians, nurses, psychologists, pharmacists, nutritionists, and chaplains. The hospital has established a dedicated "virtual" unit on the internal medicine floor, where palliative care patients with special needs can be admitted and followed more closely. The program currently handles approximately 1,000 patients each year.

When Mount Sinai introduced its palliative care program in 1997, it anticipated approximately 50 referrals in its first year but was quickly overwhelmed with business, reaching 250 new patients instead. Now the hospital follows more than 1,000 new patients each year and is in the process of developing a dedicated inpatient palliative care unit.

Weissman says, "Palliative care medicine is not a lower level of care, but just the opposite. It's a lower cost of care. It's just that our care may not involve ordering a CT scan every few days."

Meier concurs. "Palliative care medi-

Resources

The following websites provide more information about palliative care medicine.

What is palliative care?

www.getpalliativecare.org

Help for hospitals developing palliative care programs: www.capc.org

Palliative Care Leadership Centers:
www.capc.org/pclc

**National Quality Forum
Palliative Care Framework:**
www.qualityforum.org/publications/reports/palliative.asp

Palliative Care perspectives and blog:
www.pallimed.org

cine is about providing the right care at the right time for the right patient." ■
Susan Meyers is an Omaha, Nebraska, based freelance writer.