Why Palliative Medicine?

Ryan R. Budwany, M.D., M.P.H.

Kristin D. Forner, M.D.
Committee on Palliative Care

My interest in palliative medicine piqued as I sat at the bedside of my grandfather during his last few weeks of life. He was one of the 10-20 percent of cancer patients who could not obtain pain relief from medical management alone; the knowledge and skillset of the pain medicine-trained and palliative medicine-trained anesthesiologist finally brought him relief.[1] This anesthesiologist saw my grandfather's struggle, and he and his interdisciplinary team gave to each of us comfort, peace and dignity during his last days.

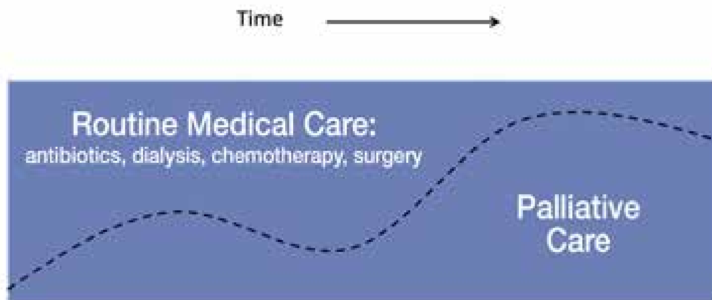
What Is Palliative Medicine?

Palliative medicine is the medical subspecialty that focuses on the treatment of seriously ill patients and their families. For clarification purposes, *palliative care* is patient- and family-centered care that attempts to optimize quality of life and minimize burden of disease.[2] I refer to both in this article.

The word "palliative" is derived from the French word *palliatif* or the Latin word *palliativus*, meaning "under cloak or cover." Palliative care physicians, with the help of an interdisciplinary team, work to both literally and figuratively come around their patients and cloak their suffering. An interdisciplinary palliative care team consists of physicians, advanced practitioners, nurses, social workers, chaplains, and sometimes pharmacists, psychiatrists and physical therapists. This kind of team brings together multiple areas of expertise to address the physical, emotional, spiritual and social concerns that can arise in the setting of serious illness.

Ryan R. Budwany, M.D., M.P.H., is Candidate for MBA Dartmouth Senior Partner at On Doctoring Consulting, West Virginia University, Department of Anesthesiology, Morgantown, West Virginia.

Kristin D. Forner, M.D., is Assistant Professor, University of North Carolina, Mission Palliative Care, Mission Hospital, Asheville, North Carolina.



While palliative care and hospice care can sometimes have overlapping goals, they are not the same. Palliative care is not constrained to an expected prognosis as hospice care is, so patients may receive palliative care at any stage in the course of their serious illness, and they may receive curative treatment alongside palliative treatment.[3] Thus, all hospice care is palliative, but not all palliative care is hospice care.

Why Is Palliative Medicine Beneficial?

When palliative care teams become involved, patients' symptoms are better discovered and managed, and they experience reduced health care expenditures, better achievement of their care goals and – in some illnesses – improved survival.

- A retrospective chart review from MD Anderson shows that palliative care teams found over five times the number of symptoms as referring teams and, in the majority of patients, were able to manage these symptoms in less than 72 hours.[4]
- Data from the Palliative Care Leadership Centers' Outcomes Group demonstrates that patients who receive in-hospital palliative care services experience better quality of care at reduced costs, regardless of whether they die in the hospital or are discharged alive.[5]
- Most patients prefer to die outside of a hospital.[6] When there are at least 30 days between the referral to an inpatient palliative medicine consultation service and the time of death, more patients die at home or in an inpatient hospice facility.[7]
- A 2010 study from Massachusetts General Hospital shows that early palliative care alongside standard oncologic care in the treatment of metastatic non-small cell lung cancer results in significant improvements in patients' quality of life and mood, greater documentation of patients' resuscitation preferences and a survival benefit of over two months.[8]

How Does Palliative Medicine Naturally Fit Into Our Scope of Practice?

Most anesthesiologists are not trained in palliative care; however, all anesthesiologists are capable of providing primary palliative care. Primary palliative care is defined as the basic communication and management "skills and competencies required of all physicians and other health care professionals" who care for patients with serious illness.[9]

Anesthesiology, as a field, provides a few avenues where quality primary palliative care could make an extraordinary difference for this patient population. There are four areas, in particular, where our skillset can be uniquely critical:

- Interventional pain management
- Sedation near the end of life
- Discontinuing mechanical ventilation
- Organ donation.

Anesthesiologists receive unparalleled education and training in analgesic and sedative pharmacology and titration, and procedural interventions for pain management. We care for critically ill patients every day. We regularly treat patients for anxiety and agitation and help them cope with their new illness-related realities. We are airway experts and thus intimately know how to comfortably intubate and extubate patients. And when patients have agreed to donate their organs, we are the ones who are called to transport them to and care for them during their very last breaths.

Continued on page 12

	Palliative Care	Hospice Care
Type of illness	**Serious Illness – Curable, Chronic or Life-Threatening**	**Life-Limiting Illness**
Eligibility	Any Stage of Illness	Prognosis ≤6 months
Goals	Continue Curative Treatments, Maximize Quality of Life, Relieve Suffering	Maximize Quality of Life, Relieve Suffering, Allow Natural Dying Process
Reimbursement	General Insurance	Medicare Hospice Benefit

Continued from page 11

What Are the Training Requirements for Specialization in Palliative Medicine?

Specialization in palliative medicine, however, becomes necessary when patients require more complicated symptom management or goals-of-care conversations. At this point, anesthesiologists without specialty training reach the limits of what they can provide these patients.

"A 2010 study from Massachusetts General Hospital shows that early palliative care alongside standard oncologic care in the treatment of metastatic non-small cell lung cancer results in significant improvements in patients' quality of life and mood, greater documentation of patients' resuscitation preferences and a survival benefit of over two months."

Although palliative care has been around for nearly half a century, the field is presently rapidly expanding, and the unmet need is enormous. The American Academy of Hospice and Palliative Medicine (AAHPM) estimates that approximately 4,400 physicians are currently practicing palliative medicine, but many only part-time. Thus, this number translates to an estimated 1,700-3,300 current-day FTEs. However, a physician-specific workforce study that was commissioned by AAHPM in 2010 reported that 10,810 palliative care physician FTEs are needed to meet the demand, which is equivalent to 6,000-18,000 individual physicians.[10] As the baby boomer generation continues to age, this number will only rise. We need more physicians specializing in palliative care!

Ten years ago, in 2006, the American Board of Anesthesiology acknowledged subspecialty certification in hospice and palliative medicine. The fellowship is a one-year combined fellowship where physicians are trained in both hospice care and palliative care. As of 2014, there were 117 anesthesiologists board-certified in hospice and palliative medicine. There are on the order of 100 fellowship programs across the country, and the number of programs open to accepting anesthesiologists grows each year. There is a complete list available on the AAHPM Connect website.

As I continue my training, I am reminded of the gift the palliative medicine-trained anesthesiologist gave my grandfather and my family ... not just a procedural intervention, but three weeks of pain-free quality time. I am humbled by these kinds of challenges in patient care, but inspired to make such a difference. Would you consider joining me in this noble pursuit?

References:

1. Ahmedzai S. New approaches to pain control in patients with cancer. *Eur J Can.* 1997;33(Suppl 6):S8–14.
2. *UNIPAC 1-9, Hospice and Palliative Care Training for Physicians, 3rd ed.*, AAHPM, 2008
3. Forner K. Palliative Care and the Perioperative Surgical Home. *ASA Monitor.* 2015;79:28-30.
4. Braiteh, Fadi et al. Characteristics, findings, and outcomes of palliative care consultations at a comprehensive cancer center. *Journal of Palliative Medicine* 2007;10:948-55.
5. Morrison, R. Sean et al. Cost savings associated with US hospital palliative care consultation programs. *Archives of Internal Medicine* 2008;168:1783-90.
6. Wilson, DM et al. The preferred place of last days: results of a representative population-based public survey. *Journal of Palliative Medicine* 2013 February 19.
7. Poulose, JV et al. Association between referral-to-death interval and location of death of patients referred to a hospital-based specialist palliative care service. *Journal of Symptom Management 2012 Nov 21.*
8. Temel, Jennifer et al. Early palliative care for patients with metastatic non-small-cell lung cancer. NEMJ 2010;363:733-42.
9. von Gunten CF. Secondary and tertiary palliative care in US hospitals. *JAMA.* 2002;287:375-81.
10. Lupu D. Estimates of Current Hospice and Palliative Medicine Physician Workforce Shortage. *Journal of Pain and Symptom Management.* 2010;40:899–911.