Hospice and palliative medicine:

Surgeons effectively push for new specialty

by Lola Butcher

Geoffrey P. Dunn, MD, FACS, saved many lives through his work in the operating room. But he has experienced a different kind of professional satisfaction from situations in which death was the inevitable outcome.

"If you can guide a person and a family through all the uncertainty of a progressive illness that you know is going to result in death, if your guidance can allow them to get as much as they can out of their life under those circumstances, it's a tremendously fulfilling feeling," he said. "Believe me, I have a lot more cards and letters from families I did that for than from people whose lives I did save."

Dr. Dunn is one of nearly 3,000 physicians certified by the American Board of Hospice and Palliative Medicine. Its decade-long campaign to advance the field will hit a milestone this year when the first hospice and palliative medicine certification examinations recognized by the American Board of Medical Specialties (ABMS) are administered.

The ABMS approved the creation of the new subspecialty in 2006, the same year that the Accreditation Council for Graduate Medical Education voted to begin accrediting hospice and palliative medicine fellowship programs.

This acceptance is unique because it is the first time that 10 medical specialty boards—including the American Board of Surgery (ABS) along with the boards of anesthesiology, emergency medicine, family medicine, internal medicine, pediatrics, physical medicine and rehabilitation, psychiatry and neurology, radiology, and obstetrics and gynecology—joined together to sponsor a new subspecialty.

"This creates a historic challenge because nobody's ever done this before," said Charles F. von Gunten, MD, PhD, provost and vice-president of the Center for Palliative Studies at San Diego (CA) Hospice and Palliative Care.

Dr. von Gunten's program—one of the largest academic hospice programs in the nation—trains internists, family physicians, and surgeons who are preparing for careers in hospice and palliative medicine.

"[Compared with] any other specialty, physicians differentiate early on and don't jump fences like that," he said. "Surgeons should be proud that they're in there at the beginning of this subspecialty and that the field is open to them."

What it means to surgeons

In the two years since the ABMS created the new hospice and palliative medicine subspecialty, nearly a dozen surgeons have contacted Frank R. Lewis, Jr., MD, FACS, ABS executive director, to inquire about details. Of those, maybe half have indicated plans to register for the examination. Most of them are in their 50s, looking for a mid-career change, Dr. Lewis said.

"All the physicians I have talked to have been surgical oncologists who have gravitated to the treatment of terminally ill patients," he said.

Meanwhile, Dr. von Gunten's fellowship program includes three surgeons, all of whom are certified in obstetrics and gynecology, preparing for a career change.

Approximately 5 percent of the physicians currently certified in hospice and palliative medicine have a primary certification in surgery—and no one expects that the formal recognition of the new subspecialty will increase that proportion.

That said, the individuals who pushed for the ABMS recognition say it has important ramifications for all surgeons. At the broadest level, Dr. von Gunten said, the creation of the subspecialty makes it official: "All of organized medicine agrees that there is specialist knowledge and specialist expertise that exceeds that of the physicians trained in any other way."

That statement liberates surgeons in two ways: They are not expected to be medicine's top experts in pain management and end-of-life care—and can stop feeling guilty about their lack of expertise—and they know specialists are available to help them provide this care for their patients.

"The relief is 'Now I know where to turn,'" Dr. von Gunten said.

The new subspecialty embraces two situations that surgeons frequently encounter.

Hospice care—which Dr. Dunn refers to as "palliative care at the very end of life"—is relevant to surgeons treating patients whose life expectancy is six months or less.

"But palliative care is a much bigger tent than just hospice," he said. "Palliative care is a conceptual framework for medical care. No matter how

much we value preservation and prolongation of life, it should always be with a concurrent goal of the release of suffering and the promotion of a person's quality of life."

Dr. Dunn believes the subspecialty will attract some young surgeons interested in the research opportunities within the field and middle-aged surgeons who want to redirect the focus of their work.

Beyond that, he sees four levels of engagement for active surgeons:

- Basic: Understanding of when and how to refer patients for hospice or palliative care specialists
- Supportive: Using leadership opportunities, such as service on ethics, critical care, or other committees, to extend surgeons' awareness and consideration of hospice and palliative care services and concepts
- Advocacy: Service of a palliative care or hospice team
- Research: Subspecialty certification as a preface to conducting research in palliative and hospice care, a field that is expected to attract many participants and have enormous impact

One surgeon's experience

Dr. Dunn was at the prime of his career—chief of surgery at Hamot Medical Center in Erie, PA—in 1995, when he decided to take a leave of absence from his work.

In hindsight, he sees a series of life experiences and recurring concerns that led him out of the operating room and onto a new path. But that pattern was not evident to him at the time. "A lot of people thought I was nuts," he said.

A fourth-generation surgeon, Dr. Dunn was trained with the Harvard Surgical Service at the New England Deaconess Hospital (now Beth Israel Deaconess Medical Center). While learning to treat severely ill patients, he perceived a disconnect between the excellent clinical care that patients received and the missed opportunities to provide spiritual and social solace to those who needed it.

"Even as early as my residency, I saw what I thought were great shortcomings and outright failure in the care of people with very advanced disease," he said.

Returning to his hometown, Dr. Dunn developed a busy general surgery practice, treating burn and trauma patients along with cancer and pediatric patients and the variety of cases that come with service in a community hospital.

In 1988, he joined a group of local volunteers who traveled to a very poor city in India, where they delivered operating room equipment and trained hospital employees on its use. There he encountered the cultural phenomenon of intentional burns inflicted on women who were suspected of adultery or who failed to provide sufficient dowry for a marriage.

"I very quickly learned that because of the extent of these kinds of burns—usually 80 percent to 90 percent of the total body surface area—there really was no chance for survival," he said. "Without calling it such, I was in a burn hospice."

Almost all the patients died, but Dr. Dunn found something was salvaged by their time in the burn unit.

"Their symptoms were obviously horrifying, but these people at least had a chance to have their dignity restored," he said. "I learned the importance of spiritual support and saw the value of family support where they were actively participating in care. And in many ways, I felt sort of transformed myself although I didn't recognize it at the time."

That transformation took another step in 1994, when Dr. Dunn's mother died of breast cancer, providing him an insight into what a good death can look like.

"If you were to look for an example of what you want end of life to be, hers would be a pretty good example in terms of the resources, the quality of life, what she was able to accomplish," he said. "That provided a personal and emotional counterpoint to the intellectual things that were beginning to gestate in my mind."

The next year, shortly after he stepped away from his surgery practice, a hospice asked him to serve as a part-time medical director. There, Dr. Dunn found his calling.

"When I saw the problems of getting access to good hospice care, the problems brought on by advanced oncologic illness, advanced congestive heart, neurological problems—and how little preparation there was in the medical field for

even communicating about these things, let alone remedying the clinical problems—it really opened my eyes," he said. "And at that point, I thought, 'This is where I need to be.'"

A couple of years later, one of his former partners asked Dr. Dunn to fill in when a scheduled speaker for a local ACS chapter meeting cancelled at the last minute. As he began telling his former colleagues about his new work, he was struck by how much patients could benefit if surgeons were more knowledgeable about palliative care and hospice options—and how much the hospice field could benefit from surgeons' knowledge of complex medical problems.

"That marked the beginning of my trying to pull the world of hospice and palliative medicine right into the world of surgery," he said.

A time of transition

Dr. von Gunten, editor-in-chief of the *Journal of Palliative Medicine*, and other advocates of the new subspecialty spent a decade—1996 to 2006—trying to win ABMS recognition.

"To some people, that seems very long, but from the ABMS point of view, which has a much longer view of life than we do, that actually is about as short as it possibly could have been," Dr. von Gunten said.

ABMS recognition required demonstration of the following three broad domains:

- Hospice and palliative medicine uses a new and distinct body of knowledge that does not overlap with other existing specialties
- A course of training that imparts that specialty knowledge is available
- There is a job—a practice of medicine—that uses this specialized knowledge

With ABMS recognition in place, the American Board of Hospice and Palliative Medicine has discontinued its certification process. Physicians who hold this certification must take the new ABMS examination before 2012. Beginning in 2013, only fellowship-trained candidates will be eligible for the exam—which creates an urgent need for more fellowship programs.

With 4,000 hospice programs and 6,000 hospitals in the U.S., each of which should have at least one physician certified in hospice and palliative medicine, the subspecialty's ranks—approximately 3,000 physicians—need to grow significantly.

Currently, 61 fellowship programs across the country train approximately 150 physicians each year, Dr. von Gunten said, adding, "That capacity clearly needs to double or triple. Having a stable source of funding is going to be key to that."

He encourages members of the American College of Surgeons to advocate for establishing more fellowship programs—and more positions in existing programs. Other ways for surgeons to participate in the advancement of the hospice and palliative care field include the following:

- Attend skill-building educational sessions at the Clinical Congress
- Participate in a growing number of conferences and continuing-education offerings that will emerge to spread the skills of hospice and palliative medicine to physicians in many disciplines
- Consider "mini-residencies"—generally one or two weeks in duration—that allow surgeons to gain experience in hospice and palliative medicine at the bedside

Much to learn about pain and death

Before coming to the ABS, Dr. Lewis spent more than 20 years as a trauma surgeon in charge of a critical care unit. He treated hundreds of patients on life support with mechanical ventilators. Invariably, high-dose opiates were used—sometimes for months at a time—to minimize pain and suppress the cough reflex. Conventional wisdom would suggest a high incidence of addiction.

"And yet, in every instance, those people, if they got better, were weaned off the opiates without any trouble, were extubated, returned to a state of health, and were totally free of opiates," he said. "In all that time, I never saw a single person who was addicted."

Understanding why those patients did not become addicted to opiates could reduce some of the fear associated with prescribing pain medication for severely ill patients. That aspect requires research, which is a significant need in medicine's newest subspecialty.

Dr. Dunn listed broad research areas—ethics, quality of life, symptom control—that cry out

for attention, along with specific research questions that every hospice worker wonders about. For example, what is the proper role of forced nutrition in most advanced illness?

He believes some physicians will be attracted to the subspecialty because America's aging population will bring the questions to bear with ever-increasing frequency. At the moment, the research methods appropriate for palliative care and hospice medicine are still being worked out, along with the evaluation and interpretation of evidence.

For hospice patients, successful therapy does not affect the disease state; its impact is on the experience of the patient and his or her family members.

"These are harder things to measure than, say, did the size of the lesion shrink from five centimeters to two centimeters," Dr. Dunn said.

What every surgeon should know

Many surgeons have little experience with managing chronic pain or referring patients to hospice—and are not eager to acquire such experience. But Dr. Dunn is encouraged by the universal acknowledgement that those skills are needed for surgery patients.

"What amazes me is that, when I talk to surgeons about this, I don't think I've ever been given the brush-off," he said. "Whether they're comfortable with it or not, they always say, 'This is really important.'"

Believing that patients deserve more than lip service, he wants all surgeons to achieve a minimum threshold of competence.

"You should not call yourself a surgeon if you do not know how to appropriately communicate bad news and appropriately manage acute or uncomplicated chronic pain," he said. "And if you're calling yourself a surgeon, you should know how to appropriately refer to hospice services."

In his view, physicians who have never sent a patient to hospice are denying them an appropriate form of care. The recognition of hospice and palliative medicine as a subspecialty is a big step toward making it professionally unacceptable to allow a patient to suffer unrelieved pain or to die without access to the support system that is available. The beneficiary is not only the patient and family, but also the surgeon who recognizes and makes use of the resource.

"From time immemorial, surgeons have been proud of the fact that they could relieve suffering," he said. "There's nothing different about that now—but what we can do for people is a lot more complex and effective." Ω

***Ms. Butcher** is a freelance writer in Springfield, MO.*