

Postgraduate
PALLIATIVE MEDICINE
training for the surgeon:

*An update on
ABMS subspecialty
certification*



*by Michael D. Adolph, MD, FACS;
and Geoffrey P. Dunn, MD, FACS*

In 1997, the *Bulletin* made a farsighted decision in publishing a brief article to raise surgeons' awareness about the (then) very new field of palliative care.¹ Now, following a decade of support from the American College of Surgeons and the equally farsighted decision of the American Board of Surgery (ABS) to co-sponsor new subspecialty board certification in hospice and palliative medicine, surgeons have the opportunity for formal training in this rapidly expanding field. Available evidence suggests that hospital-based palliative care programs are rapidly diffusing throughout the U.S. health care system. According to the Center to Advance Palliative Care (CAPC), a clinical palliative care program existed in more than 31 percent (1,299) of 4,136 hospitals appropriate for palliative care in 2008 (the analysis excluded rehabilitation and psychiatric facilities).² This growth reflects an increase from just 632 programs in 2000. Hospitals with palliative care consultation services, as compared with peer organizations, were more likely to have a cancer program approved by the ACS, to have greater than 250 beds, and to be a member of the Council of Teaching Hospitals.² Nearly 50 percent of hospitals located in cities with populations larger than 1 million have palliative care services. Hospital-based palliative care programs have proliferated in the past 10 years, and the surgeon is likely to experience more frequent clinical interactions with palliative care services in their hospitals (see box, page 8, for definitions of terms related to palliative care). Despite this growth in hospital-based clinical palliative care programs, the organization of formal fellowship training programs for physicians has lagged behind this growth.

The rationale for palliative care

There are currently 36 million Americans older than 65 years; 90 percent have one chronic illness, and more than 77 percent have two or more chronic illnesses.³ The CAPC notes that,

[B]y 2030, it is expected that the number of older Americans will have more than doubled to 70 million—or one in every five Americans. With the availability of advanced medical technologies the growing number of older adults are expected to live longer, but often with serious, chronic, and costly illnesses. By improving physical and

psychological symptoms, caregiver well-being, and patient/family/doctor communications, palliative medicine is widely viewed as an important solution to the mounting problems faced by patients, families, and the health care system.²

Analysis of approximately 1.5 million annual Medicare beneficiaries revealed that up to 31 percent undergo surgical procedures in the last 12 months of life.⁴ Typical procedures included intubation and tracheostomy (10.7 percent), hip and femur surgeries (5.63 percent), feeding tube placement (5.25 percent), colon resection (1.82 percent), enterolysis (1.24 percent), and lower extremity amputation (1.18 percent). In 1999, 50 percent of feeding tube placements and 60 percent of intubations and tracheostomies were performed on people who would soon die. In addition, the majority of injections for esophageal varices and brain biopsies in study years 1985 and 1999 were performed on patients who would die during that hospital stay.⁴ The trajectory of illness for Medicare beneficiaries and other chronically ill persons appears to frequently cross the path of a surgeon shortly before the end of life.

The rationale to justify the training of surgeons to deliver palliative care has been described by other authors.^{5,6} Briefly, on an individual patient basis, the surgeon understands surgical illness and can place it in the context of overall patient welfare, including indications and contraindications for palliative surgery.^{1,7,8} Surgeons are committed to the primacy of patient welfare as a responsibility of professionalism.⁹ In addition, surgeons feel comfortable with complex illness and routinely encounter complex family dynamics within complex health care organizations—all frequent themes found in the delivery of palliative care.

On a public health level, surgeons may be the ideal clinicians to offer and provide palliative care concurrently with curative measures when surgical disease trajectories are uncertain. The literature on end-of-life care is replete with the incorrect assumption that terminal illness defined retrospectively carries no distinction from terminal illness defined prospectively.^{10,11} Advances in technology, therapeutics, and surgical techniques have rendered prognosis more uncertain for the patient, family, and clinician.

Although training in palliative medicine may help a surgeon recognize and manage imminent death, predicting imminent death with certainty for all patients remains difficult. Lamont and Christakis describe the difficulty physicians experience when trying to relieve uncertainty by prognosticating outcomes such as death.^{12,13} They propose that a physician who demonstrates transparency must be able to communicate uncertainty while delivering simultaneous curative and palliative care in order to relieve patient

distress. Mosenthal and colleagues describe a successful interdisciplinary palliative care approach to accomplish effective communication, regardless of prognosis, in a trauma intensive care unit (ICU) environment.¹⁴

Myers and Linder have emphasized a concurrent “progressive palliative care” that readily applies to surgical practice—that is, working with patients to limit suffering while the trajectory of disease unfolds over time, not solely reserving palliative care for “crisis management at the

DEFINITIONS related to palliative medicine and hospice care

The Center for the Advancement of Palliative Care (CAPC) states that “Palliative care is the medical subspecialty focused on relief of the pain, symptoms and stress of serious illness. The goal is to ensure the highest quality of life possible for patients and their families. Palliative medicine treats serious illness regardless of prognosis, and patients can receive it at any point in their illness, with or without curative treatment.” The World Health Organization’s definition is that “Palliative care improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support to from diagnosis to the end of life and bereavement” (<http://www.who.int/cancer/palliative/en/>).

Palliative care is defined by the CAPC as follows:

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten or postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patient’s illness and in their own bereavement
 - Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated
 - Will enhance quality of life, and may also positively influence the course of illness
 - Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications

The discipline of palliative medicine is what physicians do, whereas the discipline of palliative care is what clinicians of all backgrounds—including physicians, nurses, clinical pharmacists, psychologists, social workers, chaplains, and many other specialists—may do.

According to Osoba,* as cited by McCahill et al, “Palliative surgery is best defined as surgery aimed at alleviation of patient symptoms and improvement of patient quality of life, with minimal anticipated impact on overall patient survival.”¹⁶

A hospice is an organization, health care benefits structure, or clinical practice devoted to providing interdisciplinary palliative care for terminally ill patients and their families in the home setting, skilled nursing facility, or inpatient hospice unit.

*Osoba D. Rationale for the timing of health-related quality-of-life (HQL) assessments in oncological palliative therapy. *Cancer Treat Rev.* 1996;22(Suppl A):69-73.

end of life.”¹⁵ The cancer patient, however, may represent a more predictable prognosis based on disease trajectory; as Scitovsky notes, “It is no accident that hospice programs serve primarily [cancer] patients.”¹⁰ Although uncertainty may be a hallmark of many surgical illnesses, the benefits of a concurrent palliative care approach are within the capabilities of the surgeon. The surgeon is also uniquely skilled to evaluate the risks and benefits of palliative surgery or interventional procedures to best achieve quality of living. How does the surgeon acquire training to provide for more effective communications (for example, in delivering bad news¹⁶), to enhance patient-family decision making, and to relieve distressing symptoms?

Educational opportunities

If you provide surgical care for chronically ill, critically ill, or terminally ill patients, there are benefits from additional training, resources, and support to deliver palliative care concurrently with standard curative measures or at the end of life.^{5,6,17} Recognizing the benefits of palliative care for surgical patients, the ABS became one of 10 sponsoring boards for subspecialty training in palliative medicine.¹⁸ Perhaps the seeds for this commitment were sown in 1997 by the *Bulletin* article mentioned previously, which recognized the palliative care needs of surgical patients. Shortly after the article was published, a well-attended colloquium on end-of-life care—presented at the 1997 Clinical Congress in Chicago, IL, and moderated by Thomas Krizek, MD, FACS—addressed the nationally debated topic of physician-assisted suicide. Both sides of that debate at least agreed that palliative care is essential for good patient care and that surgeons had much to learn in order to provide it. Many of the panelists subsequently drafted the College’s first Statement on Principles of Care at the End of Life, which was approved by the Board of Regents in February 1998.¹⁹

In 2001, the College received a grant from the Robert Wood Johnson Foundation that provided initial funding of the Surgical Palliative Care Task Force in the Division of Education. The initial purpose of the Task Force was to raise surgeons’ awareness of the palliative care needs of their patients and to provide educational op-

portunities about the principles and techniques of palliative care in surgical practice. The task force has contributed to a valuable position paper,¹⁹ monthly journal articles for the *Journal of the American College of Surgeons (JACS)* over a period of three years,²⁰ an educational Web portal,²¹ and symposia at the ACS Clinical Congress every year since 2000. Additional available educational resources for the practicing surgeon are thoroughly described in a review by Brasel and Weismann in *JACS*.²² Supported by the ACS Board of Regents, the task force continues to develop and promote learning activities within the ACS Division of Education.

Palliative care services are generally codified and billed by evaluation and management service Current Procedural Terminology codes on the basis of time spent, symptoms managed, and/or care coordinated. Charges are typically codified with a submitted claim’s first International Classification of Diseases, Ninth Revision, code to reflect the dominant symptom or sign prompting palliative care interventions (for example, the first code on the claim would be abdominal pain, 789.0; or neoplasm-related pain, 338.3; or encephalopathy, 348.39). If billing for time spent, documentation in the medical record should reflect total time spent as well as the clinical focus of timed efforts (for example, medication counseling, coordination of care, or end-of-life goal setting).²³

Practice pathways and board certification

Ultimately, the American Board of Medical Specialties (ABMS) unanimously approved palliative medicine as a subspecialty in 2006, affording it all of the rights and privileges of other subspecialty training tracks leading to board certification.^{18,24} Given the support of the ABS as a sponsoring board, surgeons may pursue subspecialty fellowship training in palliative medicine toward an ABMS-approved board certification in palliative medicine. How does a surgeon train in palliative medicine, and why? How does a surgeon integrate palliative medicine fellowship training into a surgical career?

Training in palliative care during postgraduate surgical residency is limited and very early in its development, though surgical residents frequently encounter patients with terminal or

incurable illness.^{22,25,26} For example, the management of malignant bowel obstruction requires complex decision making involving palliative,²⁷ ethical,²⁸ and interdisciplinary²⁹ considerations.

Limited work hours and a jam-packed curriculum in surgical training result in precious few opportunities for added training of any sort. However, Klaristenfeld and colleagues have demonstrated that three one-hour palliative care teaching sessions for surgical residents proved helpful and led to retained knowledge at a three-month reevaluation.³⁰ Chipman and colleagues at the University of Minnesota developed an Objective Structured Clinical Exam (OSCE) for leading family conferences in the surgical ICU. The surgical ICU OSCE required surgical residents to lead an end-of-life discussion and to disclose an iatrogenic complication.³¹ Surgical educators and mentors of young surgeons can help trainees implement palliative care alternatives concurrently with surgical intervention in advanced disease or develop beneficial alternatives when surgery is not indicated.³²

Surgeons have already received certification in palliative medicine by an experiential pathway and a training pathway. Before 2008, these non-ABMS pathways were sponsored by the American Board of Hospice and Palliative Medicine (ABHPM). As of 2006, 27 surgeons were ABHPM-certified in palliative medicine, out of a total of 2,145 certified physicians in the U.S. (personal communication, Dale Lupu, PhD, ABHPM chief executive officer, July 3, 2006). Beginning in October 2008, surgeons previously certified in palliative medicine will have until 2012 to retake the new ABMS certification exam sponsored by the ABS, given every two years.^{33,34}

From 2008 to 2012, a practice pathway is still available for physicians already involved in hospice or palliative care, including surgeons. Surgeons involved in interdisciplinary care of chronically diseased, critically ill, or terminally ill patients are candidates to apply for the examination. Applicants must be able to document at least 800 hours of clinical involvement in the subspecialty-level practice of hospice or palliative medicine. The 800 hours must have been completed over at least two years and include 100 hours of participation with a hospice or palliative care team, as well as participation in the

active care of 50 or more terminally ill patients (or at least 25 patients for pediatric surgeons). Diplomates who were previously certified by the ABHPM may also enter through this ABMS pathway, with their previously earned certificate documenting their experience.

For the training pathway, until 2010, 12-month fellowships in palliative medicine associated with an academic program approved by the Accreditation Council for Graduate Medical Education (ACGME) (for example, a palliative medicine fellowship associated with an ACGME-approved internal medicine or anesthesiology academic program) qualify a graduate to sit for the palliative medicine board exam. After 2010, completion of an ACGME-certified palliative medicine fellowship will be necessary for all other surgeons to achieve palliative medicine board certification. To date, the authors are aware of only two surgeons who have completed fellowship training in this relatively new subspecialty. Given that surgeons represent only 1.2 percent of existing board-certified palliative medicine physicians, the evidence suggests that additional surgeons are needed in this calling to provide expertise in this growing subspecialty.

The chief prerequisite to apply for a palliative medicine fellowship is that one simply needs to be board certified or board eligible in surgery. An additional key component to success in palliative care training is the desire to help incurably diseased or chronically ill patients improve the quality of living for themselves and their families in the short or long term. Fellowship curricula and competencies are complementary to surgical care.³⁵⁻³⁷ If you have felt the frustration of realizing that you cannot cure Crohn's disease or chronic bowel obstruction caused by adhesions, atherosclerosis, or disability as a result of cancer treatments, you are familiar with the needs of the chronically ill. Perhaps you simply have a desire to do more when your instincts tell you that a surgical cure is not feasible, particularly near the end of a patient's life or for critically ill patients and their families. You may simply feel the need for more training or resources to meet the demands of disabling disease. The palliative medicine fellowship teaches physicians how to deliver bad news more effectively and engage the patient and family in the process. Participants

also learn to implement and maintain comfort in practical terms. This approach permits patients and families to develop and achieve new goals and relief from suffering caused by chronic illness or at the end of life.

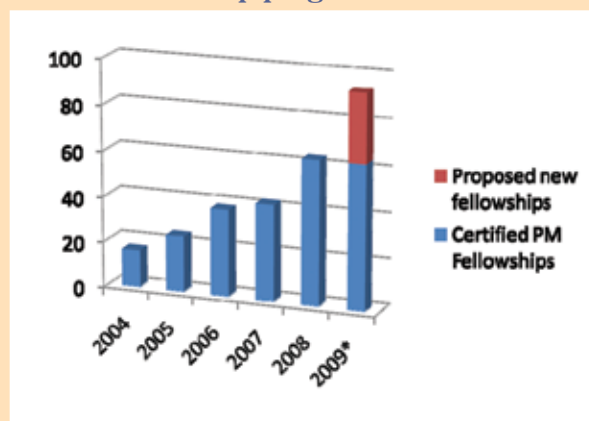
It can take courage to help patients and families confront obstacles in chronic illness or at or near the end of life. A surgeon already has the boldness needed to help the most vulnerable of patients in complex, life-threatening medical situations. Finally, an innovative spirit helps fellowship applicants. The authors have never met a surgeon who didn't have an innovative spirit to meet the challenges of a new field. It not only takes a desire to improve patient care at the bedside but also the recognition that the way that entire organizations "do" health care for chronic and advanced illness needs to change. And, at this juncture in the development of this subspecialty, participating surgeons will be at the focal point of that change in their institution or specialty practice.

Approval by the ACGME provides national academic stature for the subspecialty and encourages the development of competency standards as fellowships expand.³⁷ Currently there are 63 fellowships available, with 161 annual positions to fill. Approximately 30 more anticipated fellowships will begin filling in 2009 (see Figure, this page). Training is typically 12 months in duration. Future applications for fellowships will likely be through the electronic ERAS system, similar to other postgraduate training program applications today (see <http://www.aamc.org/audienceeras.htm>). A listing of current fellowships is located on the American Academy of Hospice and Palliative Medicine (AAHPM) Web site at <http://www.aahpm.org/fellowship/directory.html>.

Integrating palliative care to practice

What are the available professional opportunities and how does a surgeon integrate palliative medicine expertise? Currently, the most common model is a practicing general surgeon who also provides state-of-the-art palliative care to his or her own patients or to the patients of other clinicians by consultation. However, it is also clear that the patient populations of many surgical subspecialists have unique palliative care needs. These palliative care needs may be best met by

Figure. Total ABHPM-certified U.S. palliative medicine (PM) fellowship programs in the U.S.*



*Beginning in 2009, programs will be certified by the ACGME (personal communication, AAHPM, 2008).

the surgeons delivering the care themselves. For example, there are exclusive needs to be met for cancer patients,⁷ the critically ill,³⁸ transplant patients,³⁹ and patients afflicted by trauma⁴⁰ or burns.⁴¹ Critical care specialists already have some of the most well-developed consensus palliative care guidelines available today.⁴²

What about the mid-career surgeon? One of the reasons the 10 specialty boards unanimously approved palliative medicine as a subspecialty was to encourage mid-career physicians and surgeons to participate in the growth of this young specialty. After fellowship training, one could also conceivably take a path of full-time palliative medicine or hospice clinical work, because demand for physicians far exceeds supply. In all of these opportunities, surgical background and surgical approach to problem solving is invaluable.

Interested surgeons will want to evaluate a fellowship training program closely, as fellowships are a heterogeneous group. How did the clinical program begin? What is the historical background of a fellowship program? For example, the service at Ohio State University started as an anesthesiology cancer pain service (led by Costantino Benedetti, MD) at a cancer research hospital. More than 80 percent of the program's clinical work has been with advanced

cancer patients, and the program delivers expert cancer pain therapy, symptom control in chronic cancer survivorship, and support care of the dying cancer patient.

The clinical interests of the program's medical director are important factors. There is considerable professional diversity in palliative medicine right now. This professional diversity can be either a strength or a weakness when considering the depth and breadth of the fellowship experience, depending on the clinical emphasis of the program itself.

Not only do clinicians in palliative medicine determine the focus of care, but the needs of the institution itself also plays a substantial role. Is there a large medical ICU associated with the fellowship program? If so, expect a lot of inpatient end-of-life care. Is there an ambulatory clinic? For example, there are more than 12 million cancer survivors today, many of whom are living with disabling symptoms in their cancer survivorship; this is true of the majority of the 800 outpatients in the ambulatory care clinic at the James Cancer Hospital.

Conclusion

Despite evidence that hospital-based palliative care is rapidly diffusing throughout the U.S. health care system, few physicians and fewer surgeons are certified in this subspecialty. On average, only 1.7 board-certified physicians are available to serve each of the 1,299 hospital-based palliative care programs in the U.S. (2,145 physicians compared with 1,299 programs, based

on available data). The majority of the palliative medicine board-certified physicians (98.8 percent) are not surgeons. As such, there may be obstacles to this innovation diffusing through surgical patient populations. Judging from the growth of hospital-based programs, the recent ABMS subspecialty approval, and an anticipated increase in future graduates of expanding fellowship training programs, hospital-based surgeons can expect to collaborate with palliative care teams more frequently in their surgical practice.

The authors believe that surgeons actively becoming involved in palliative care education, training, and experience are the most effective means of helping surgical patients who need palliative care. Surgeons bring unique expertise to palliative medicine, and surgeons hold a unique trust with their patients for total care in complex medical circumstances. The curriculum in a 12-month fellowship is comprehensive and complementary to a surgical career. Surgeons have a unique opportunity to join and contribute to this movement, including undergoing fellowship training themselves. Postgraduate fellowships will ultimately determine what the subspecialty aspires to become in terms of research, education, and clinical care. There is also a practice pathway to board certification available until 2012. Independent of a surgeon's interest in palliative care, clinical interactions with hospital-based palliative care services are expected to increase in the near future. □

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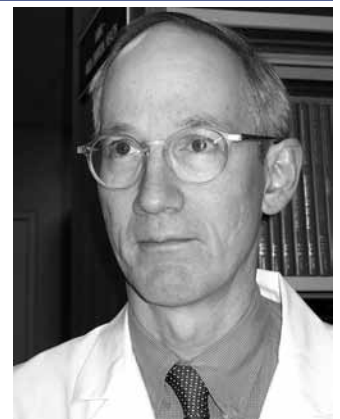


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Dr. Dunn is board certified in surgery and palliative medicine and is the chair and cofounder of the Surgical Palliative Care Task Force of the ACS Division of Education.



Call for nominations for the ACS Board of Regents

The 2009 Nominating Committee of the Board of Governors has the task of selecting three nominees for pending vacancies on the Board of Regents to be filled during the 2009 Clinical Congress in Chicago, IL. One of these pending vacancies is a Canadian seat, which, in accordance with ACS *Bylaws*, must be filled by a Canadian surgeon. The following guidelines are used by the Nominating Committee when reviewing the names of candidates for potential nomination to the Board of Regents:

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to

the highest principles of surgical practice

- Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College

- Recognition of the importance of their representing all who practice surgery

Also to be taken into consideration are geography, surgical specialty balance, and academic or community practice. The College encourages consideration of women and other underrepresented minorities.

Individuals who are no longer in active, surgical practice should not be nominated for election or reelection to the

Board of Regents. Priority consideration should be given to representatives of general surgery. Note: Consideration of the surgical specialty does not apply to the Canadian seat.

Nominations should include one or two paragraphs on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Friday, **February 27, 2009**.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Board of Governors, at psprecksel@facs.org.

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