# Palliative Care Gets ABMS Nod as Subspecialty

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The field of palliative care took a major step forward in September when members of the American Board of Medical Specialties voted to approve hospice and palliative medicine as a recognized subspecialty.

The application to recognize the subspecialty had broad support and was cosponsored by 10 medical specialty boards.

As a result, physicians in a number of specialties—including internal medicine, family medicine, pediatrics, psychiatry, neurology, surgery, emergency medicine, and obstetrics and gynecology—will be able to seek the certification.

The first certification examination is expected to be administered in 2008, according to Dr. F. Daniel Duffy, senior adviser to the president of the American Board of Internal Medicine. "It's going to be a real boost to patient care," Dr. Duffy said.

The milestone is just the latest in a series of developments in the size and status of the field of palliative care.

Between 2000 and 2004, the number of hospital-owned palliative care programs in the United States increased by nearly 75%, jumping from 632 in 2000 to 1,102 in 2004.

As of 2004, 63% of large hospitals—those with at least 200 general adult beds—reported that they had some type of palliative care program in operation, according to the Center to Advance Palliative Care.

This summer, palliative medicine received a nod from the Accreditation Council for Graduate Medical Education (ACGME) when the organization voted to approve an accreditation process for hospice and palliative medicine fellowship training programs.

ACGME is expected to begin accepting applications in summer 2007.

"We're well beyond the tipping point," said Dr. Diane Meier, director of the Center to Advance Palliative Care and director of the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine in New York.

At her institution, palliative care has become so well accepted that asking for a palliative care consult is as routine as calling for an infectious disease consult.

Physicians no longer see it as a personal failure in their treatment of the patient to get assistance from palliative care, she said.

Now the focus has shifted from selling the concept of palliative medicine to ensuring that programs around the country have consistently high standards, Dr. Meier said.

Work is already underway in this area. The National Consensus Project for Quality Palliative Care, which is sponsored by three national palliative medicine organizations, has released quality guidelines.

These guidelines include having interdisciplinary teams, making grief and bereavement services available to patients and families, and providing evidence-based pain and symptom relief, among others.

The standards are a guidepost but will be challenging for smaller programs, Dr. Meier said, and should be filtered by the size of the facility, the staff available, and the needs of the institution.

The National Quality Forum approved its own framework for palliative and hospice care earlier this year.

"That's real legitimacy," Dr. Meier commented.

In an effort to ensure that new programs have high-quality processes in place, the Center to Advance Palliative Care launched the Palliative Care Leadership Centers—six centers of excellence in palliative care around the country that train teams of health care providers.

The program includes intensive, 2-day training sessions in which teams are sent to one of the six centers and leaders at the centers act as mentors for a year after training.

The cost of the program is about $1,750 for a four-person team.

When the site visits started in 2004, Dr. Meier and others at the Center to Advance Palliative Care estimated that about 30% of the teams trained would successfully establish a program, she said, but it's been closer to 70% to date.

However, the process isn't fast, and it sometimes takes more than a year for teams to get their programs up and running, she said.

The Mount Carmel Health System in Columbus, Ohio, is one of the six leadership centers. The program was launched in 1997 in an effort to treat patients with serious, advanced diseases who were not candidates for hospice care, Mary Ann Gill, executive director of palliative care services at Mount Carmel, said.

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The Mount Carmel program, which includes a palliative care consult team as well as three dedicated palliative care units across three hospitals, is popular with teams working to start programs in community hospitals.

During the training, the members of a palliative care team are encouraged to get to know each other better and begin drafting a work plan to take back to their institution.

The training focuses on the clinical aspects of the program, as well as on financial management and how to sustain the program, Ms. Gill said.

While much of the interest in palliative medicine has been from physicians at midcareer, there is increasing interest among young physicians and residents, said Dr. Philip H. Santa-Emma, medical director for the palliative care service at Mount Carmel. "I've seen a huge increase in the number of residents coming through," he said.

But the training of new physicians in palliative care also represents one of the next big challenges in the field, Dr. Meier said.

Currently there is a cap on the number of residency positions funded by Medicare, making it hard for a new subspecialty to gain a foothold, she said. Palliative care fellowships are currently funded by philanthropy.

As the field continues to move forward, there also needs to be continual education of the health care team about when to get palliative care involved, Dr. Santa-Emma said.

This is a message that has to get out to all members of the health care team, not just physicians, he said. ■



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