

Recognizing Palliative Medicine as a Subspecialty: What Does It Mean for Oncology?

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The prevention and relief of suffering are important goals of comprehensive cancer care. The development of the field of palliative care over the past 50 years is the contemporary manifestation of medical progress in meeting those goals. Palliative care grew out of, and includes, hospice care. Never before in the history of medicine has there been more ability to relieve suffering and improve quality of life throughout the spectrum of illness from diagnosis to death.

The increase in knowledge has led to the development of a physician subspecialty: palliative medicine. Palliative medicine is the medical discipline within the larger interdisciplinary field of palliative care [1]. The rationale for the development of this new physician subspecialty is no different than for the development of other subspecialties—to make new knowledge practically available to patients, families, and their doctors.

The development of a palliative care service at the Warren Grant Magnuson Clinical Center at the National Institutes of Health represents both an example and a milestone in the professional development of palliative care in the United States [2]. Similar programs have been established at Memorial Sloan-Kettering Cancer Center in New York City, the Dana-Farber Cancer Center in Boston, Fox Chase Cancer Center in Philadelphia, the Moffitt Cancer Center in Tampa, and the M. D. Anderson Cancer Center in Houston. Just as in the rest of healthcare, it is through the provision of subspecialist expertise that new knowledge is made practically available in the clinical setting. As these programs highlight, palliative care expertise is

needed in a preeminent cancer research center as it is in other clinical settings in this country.

Two Significant Signals

The advent of clinical palliative care as part of comprehensive cancer care is significant for two reasons:

- First, it signals that there need not be conflict between treatment of cancer and treatment of the suffering of the patient...and the distress of his or her family. Both are legitimate, and necessary, aims of comprehensive cancer care. Leading cancer centers will want to ensure that expert, effective palliative care is integrated into the overall treatment plan from diagnosis to death.

- Second, it signals that palliative medicine is a legitimate discipline, a discipline that employs the tools of modern clinical research in order to continue to develop new knowledge and more effective techniques for comfort care.

The development of academic palliative care has been slow but steady [3]. The first modern academic hospice, St. Christopher's Hospice, was developed by Dr. Cicely Saunders and opened in 1967. Its purpose was not just to care for those with advanced cancer but also to combine research and education with medical care in accord with the finest academic traditions. Those who studied with Dr. Saunders and her colleagues developed similar academic programs at Oxford University, McGill University, and in conjunction with Yale University.

In 1987, Dr. T. Declan Walsh developed the first US academic palliative care service as part of a comprehensive cancer center at the Cleveland Clinic [4]. Other academic units and services followed, and now many hospice programs and palliative care services in US hospitals and health systems participate in the education of medical students, resident physicians, nursing students, and other health professionals [3].

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Curricula on palliative care have been developed and broadly disseminated [5, 6]. Certifying boards recognizing the subspecialties of hospice and palliative medicine have been established for both physicians and nurses [7]. There are at least seven subspecialty peer-reviewed journals serving the field. Chapters in general medical textbooks, as well as entire subspecialty textbooks, have been published. Fellowship programs are developing to train physicians who wish to subspecialize [8].

For the oncologist, this should be welcome news. Such professionalization and subspecialization are the appropriate response to the expanding knowledge base in healthcare. Whereas every oncologist needs and uses basic skills (primary palliative care), he or she will want to be able to turn to a subspecialist for consultation about difficult cases (secondary palliative care). There is also a need for tertiary palliative care, where new knowledge is discovered and where clinicians are educated in the field [3].

Primary, Secondary, and Tertiary Palliative Care

The relationship between the field of oncology and the field of palliative care varies depending upon the needs of the patient, the family's wishes, and the preferences of the oncologist (Table 1). All oncologists need to be proficient enough to meet the basic palliative care needs of their patients. For example, oncologists manage pain and other symptoms, deliver bad news, and help patients and families cope throughout the course of care. The oncologist learns those skills during training and by reading journal articles, taking courses, and watching for the results of research that will help to improve his or her ability to relieve suffering for patients and their families.

At the secondary level of care, the oncologist asks a palliative care team for consultation. That may be a one-time event, such as asking for advice about a troublesome symptom or for help with a difficult family meeting. The palliative care team may assume responsibility for managing part of the care at the direction of the oncologist: for example, ongoing management of difficult symptoms or ongoing counseling and support of the patient or family. The patient may be moved to a palliative care unit for more intensive subspecialty care. The palliative medicine specialist consults with the oncologist, following the usual relationship of attending physician and consultant—titrating the

level of involvement to what is requested by the attending physician. Overall management responsibility remains in the hands of the oncologist unless specifically delegated. For example, the palliative medicine physician may make home visits, whereas the oncologist does not. Examples of primary, secondary, and tertiary care are shown in the three case reports discussed in this article.

Why Is a Formally Recognized Subspecialty in Palliative Medicine Needed Now?

Palliative medicine physicians participate in clinical services in more than 10% of hospitals [9], 20% of academic medical centers [10], and all hospice programs serving most geographic areas of the country. The Commission on Cancer now requires that a pain/palliative care physician or specialist be included on the cancer committee of accredited hospitals [11]. Palliative medicine has, for all intents and purposes, entered into the general fabric of care of cancer patients; it is time to “officially” recognize this development in organized medicine in this country. Although the subspecialty of palliative medicine has been formally recognized in Great Britain, Ireland, Australia, and Canada, formal recognition has not yet been obtained in the United States [12].

Formal recognition of a subspecialty enhances professionalism by creating practice standards and well-defined competencies within a specified domain of knowledge and/or practice. In palliative medicine, these competencies center on the following domains:

- relief of suffering,
- promotion of good quality of life for patients and families in the context of life-threatening illness, and
- promotion of the personal development and growth possible in the psychological and spiritual dimensions at the end of life.

The disciplined application of these competencies is necessary to improve the health and healthcare of the public. Application of the specialty's skills helps rectify the immediate problem of poor quality care. But recognition of these competencies by the larger “house” of medicine lays the foundation for sustained, long-term excellence in the relief of suffering and compassionate care of the seriously ill and dying.

Consistent application of the knowledge base of palliative medicine is not yet routine. A 1997

Table 1**Comparison of Primary, Secondary, and Tertiary Palliative Medicine**

	PRIMARY	SECONDARY	TERTIARY
Pain control	The oncologist prescribes opioids and adjuvant medications for cancer pain management.	Palliative medicine is consulted to help manage pain using drugs, doses, and schedules that are outside the comfort level of the oncologist. Psychosocial support is provided as part of the management plan.	Oncology fellows rotate with the palliative care service to learn basic and advanced approaches to pain management. Patients are enrolled in clinical trials of new agents.
Other symptom control	The oncologist manages chronic nausea with combinations of agents.	Palliative medicine is consulted for refractory nausea and vomiting. The patient is transferred to a palliative care unit, where skilled staff apply advanced approaches to symptom control. The plan to address the psychological, social, and spiritual components of the chronic nausea is consistently applied by all staff on each shift.	Palliative medicine fellows and faculty perform translational research trials of new agents. New results are presented at national meetings of oncologists. Practicing oncologists participate in courses to learn the latest approaches to symptom control.
Communication	The oncologist effectively and compassionately delivers bad news to a patient and family about worsened cancer. He or she establishes goals of care that sustain hope while avoiding false hope.	Palliative care is consulted to assist with a family meeting to discuss withdrawal of life support for a patient with multi-organ failure after bone marrow transplant, where the family's wishes have been in serious conflict with those of the patient and health-care team.	Oncology fellows rotate with the palliative care service to practice giving bad news. Patients, families, and physicians are enrolled in studies to learn new and effective ways to demonstrate cultural competency.
Spiritual distress	The oncologist is able to elicit and address the spiritual distress of the cancer patient.	Palliative care is consulted to assist with assessment and management. A chaplain from the team spends considerable time with the patient and family.	Basic research on hope, hopefulness, and the relationship with spirituality is conducted. Results are disseminated in journals and courses for oncologists.

Palliative Medicine as a Subspecialty

report from the Institute of Medicine highlighted deficiencies in the healthcare system's approach to end-of-life care and called for the development of professional expertise in palliative medicine in the United States to make this knowledge widely available to healthcare practitioners in this country [13]. The report recognized the benefits that formal recognition of palliative medicine would confer, stating that a formal specialty would, in the words of the report:

- focus attention more powerfully on an existing knowledge base that is both insufficiently understood and inadequately applied and that is in need of further growth;
- recognize more explicitly and publicly that palliative care is an appropriate goal of medicine;
- conform to the value and recognition structure of medical professionals—providing credibility with peers (and perhaps patients and others) as a source of knowledge, guidance, and referral;
- attract leaders to the field; and

- nurture the development of the field and its knowledge base.

Subsequent reports from the National Cancer Policy Board emphasize the role that palliative care needs to play as part of comprehensive cancer care [14, 15].

How Does Formal Recognition Lead to Improved Cancer Care?

Formal recognition of the subspecialty of palliative medicine will set standards on which oncologists can rely. Highly skilled subspecialists will be available to assist oncologists with the most difficult patients and support their colleagues in improving care for all patients. A new subspecialty does not mean that all cancer patients with symptoms or distress need to see a palliative medicine subspecialist.

Formal recognition also signals that the field is worthy of pursuit. A recognized field is more likely to attract the “best and the brightest” to commit their careers to further developing the field.

This means that researchers will pursue efforts to extend and refine the knowledge base of the field; teachers will train the next generation of specialists; and administrators will devote resources to the clinical, research, and teaching needs of the specialty.

Are There Risks Associated With Formal Recognition?

Creation of another subspecialty does carry risks. Subspecialization can further fragment cancer care and drive up costs by adding yet another round of consultations. Additionally, some are concerned that oncologists will “dump” responsibility for palliative care exclusively into the lap of the subspecialist and his or her team, when what patients desire and need is continuity with their primary oncologist.

Alternatively, there may be a risk of alienating oncologists who are already providing good palliative care but not identifying themselves as practicing palliative medicine. Proponents of a palliative medicine subspecialty address these concerns through careful delineation of the appropriate collaborative relationship between the consulting palliative medicine specialist and managing oncologist.

How Are Specialties Organized in the United States?

In the United States, medical specialty status is organized in two parts: (1) accreditation standards defining the training necessary to learn the specialty’s knowledge and skills and (2) certifying boards that administer independent assessments to determine that practitioners can demonstrate attainment of the knowledge and, to a lesser extent, the skills of the specialty.

In the United States, the American Board of Medical Specialties (ABMS) coordinates the activities of 24 member boards and their associated subspecialties in allopathic medicine. A similar structure has been established for osteopathic medicine. ABMS views the fundamental function of specialty boards as acting “in the public interest by contributing to the improvement of medical care by establishing the qualifications for candidates and by evaluating individuals who apply for certification. A related function of approved specialty boards is to assist in maintaining and elevating the standards of graduate medical education and facilities for specialty training, in collaboration with other concerned organizations and agencies” [16].

CASE REPORT 1

Primary Palliative Care

An 85-year-old Philippine woman has advanced breast cancer due to a neglected primary. The oncologist elicits her sense of shame that prevented her from seeking treatment earlier, her fear of doctors and chemotherapy, and her fear of being addicted to narcotics. Because of the communication skills the oncologist learned during her fellowship, she is able to establish a therapeutic alliance with the patient. She prescribes tamoxifen, long-acting morphine, short-acting morphine for breakthrough pain, a senna laxative, docusate sodium, and ibuprofen. The oncologist hosts a family meeting so that the patient’s 5 children and 12 grandchildren understand the diagnosis and prognosis, because the patient does not want to tell them.

The cancer remits over 6 months, and the level of pain medication is reduced. When the cancer recurs 3 years later, pain medications are again introduced, and an aromatase inhibitor is prescribed. This regimen leads to a shorter remission. At age 91, the cancer recurs again, and the oncologist elicits goals that include no further chemotherapy and a desire to stay at home. The oncologist refers for hospice care and remains the managing physician. The oncologist makes two home visits during the next few months. The patient dies comfortably at home 4 months later. The family is grateful.

The Accreditation Council of Graduate Medical Education (ACGME) is the organization that coordinates accreditation of physician training in residencies and fellowships in allopathic medicine. A similar structure exists for osteopathic medicine. The mission of ACGME is “to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education experiences for physicians in training. The ACGME establishes national standards for graduate medical education by which it approves and continually assesses educational programs under its aegis” [17].

Membership in ABMS and accreditation of training by ACGME are what define “formal recognition” of a specialty [18, 19]. The benefit of recognition through ACGME accreditation is very tangible: Medicare funding of fellowships is contingent on such accreditation. The benefit of membership in ABMS is less tangible and does not

directly influence reimbursement. ABMS membership is regarded as acknowledgment by the entire medical profession of the legitimacy of the practice area as a special expertise, and secondary benefits may accrue. For instance, certain states allow physicians to publicly advertise board certification only if the board is an ABMS member, some hospitals will only credential specialties recognized by ABMS, and some insurers link certain reimbursement rules to ABMS board certification.

What Is the Difference Between a Specialty and a Subspecialty?

A specialty is a recognized branch of medicine that requires continuous training from the time medical school is completed until independent practice (such as surgery or family practice). A subspecialty denotes a branch of medicine that requires additional training after an initial period of training is completed (such as hematology and medical oncology after training in internal medicine) [20]. Palliative medicine requires additional training after basic residency before it can be pursued. Therefore, it can be construed as a subspecialty.

What Are the Steps to a Recognized Subspecialty?

Both ABMS and ACGME have formal criteria and procedures for determining the need for a new specialty or subspecialty area [21]. New specialty boards are not created lightly by ABMS. Approval of new medical boards is a joint action of ABMS and the American Medical Association Council on Medical Education (AMA/CME) through a joint committee of the two organizations: the Liaison Committee for Specialty Boards (LCSB). The newest boards admitted to ABMS were Medical Genetics in 1991 and Emergency Medicine in 1979. The criteria for recognizing a new specialty are spelled out in the “Essentials for Approval of Examining Boards in Medical Specialties” as follows [16]:

- The establishment of a new specialty board signifies the differentiation of a new specialty, which must be based on major new concepts in medical science.

- A new medical specialty board must represent a distinct and well-defined field of medical practice. It may entail special concern with the problems of patients according to age, sex, or organ systems or with the interaction between patients and their environment. A new certifying board must be based on substantial advancement in medical science. The

needed training must be sufficiently complex or extended that it is not feasible to include it in established training programs.

- A specialty board must require evidence that its diplomates have acquired capability in a stated area of medicine and will demonstrate special knowledge in that field.

- A plan must be presented whereby preparatory programs in graduate medical education will be developed for accreditation by the ACGME. New boards may be permitted under conditions stated by the petitioning board and approved by the LCSB, to approve training or experience or a combination of both as equivalent to that acquired in accredited training programs until accreditation by the ACGME is in place.

The process for approval of a new subspecialty is less stringent than that for a new primary board. Whereas primary specialty applications are initiated by an outside group applying to ABMS, subspecialty applications are brought forward by member boards of ABMS. Once an ABMS member board has determined the need for a new subspecialty (using its own criteria and process, which may differ from board to board), the primary board applies to ABMS for approval. An application may be jointly presented by more than one primary board if desired.

ACGME also has formal policies and procedures that guide creation of a new subspecialty area for accreditation. Briefly, the process involves establishment of an ad hoc committee to review the petition for new specialty training, which then recommends one of three actions:

- denial,
- referral to an existing ACGME residency review committee (RRC) for consideration for inclusion in the current discipline or creation of a new subspecialty in the existing general discipline, or
- recommended for “preliminary development” as a new discipline.

ACGME and ABMS formally coordinate with each other regarding initiation of new specialty areas. When ACGME is considering a proposal for a new area of accreditation, it requires that ABMS comment on the proposal. Documentation of the communication between the relevant RRC and specialty board must clearly indicate one of the following options:

- that the board awards a certificate in the subspecialty and supports accreditation in that area, or

- that the board does not intend to award a certificate at this time but is not opposed to the RRC beginning to accredit programs in the subspecialty; or
- that the board is opposed to the accreditation of programs.

Palliative medicine is not being considered as a Certificate of Added Qualification (CAQ), rather than a subspecialty, because the ABMS decided that no further CAQs would be developed. Consequently, subspecialty recognition is the only avenue available for formal recognition.

What Progress Has Palliative Medicine Made Toward Formal Recognition?

In the past decade, palliative medicine has made significant strides toward meeting the requirements for formal recognition [7]. The number of physicians seeking certification in the field is growing; the professional association is strong; peer-reviewed research appears in seven specialized journals, as well as in journals of broader interest; and formal training programs are rapidly expanding.

PUBLICATION OF SCHOLARLY RESEARCH

The emergence of specialized journals, well-regarded textbooks, and formal curricula is an indicator of the development of a new and distinct body of knowledge. Research in the area of palliative medicine appears in at least seven specialized peer-reviewed journals:

- *Journal of Palliative Care* (Canada)
- *Journal of Pain and Symptom Management* (including supportive and palliative care; United States)
- *Journal of Palliative Medicine* (United States)
- *American Journal of Hospice and Palliative Care* (United States)
- *Palliative Medicine* (United Kingdom)
- *Progress in Palliative Care* (United Kingdom)
- *European Journal of Palliative Care* (United Kingdom).

The newest journal in the field is *The Journal of Supportive Oncology*, in which this commentary is being published. This journal is circulated to 28,600 US oncology physicians and nurses, is published 6 times a year, and has applied for inclusion in *Index Medicus*.

More than one curriculum for palliative medicine has been published [5, 6, 22]. Models to guide clinical palliative care have been disseminated

CASE REPORT 2 Secondary Palliative Care

A 48-year-old African-American attorney develops metastatic prostate cancer despite appropriate screening. Hormonal therapy slows the rate of rise of prostate-specific antigen, but bone pain, especially with movement, is still a problem. He and his wife are angry. They have three children, aged 9, 12, and 15. There are behavior problems at school. There is a suspicion that the wife is drinking too much alcohol as a coping strategy. They are financially overextended. The patient spends even more time at his law practice than heretofore and avoids his wife and children.

Experimental chemotherapy combined with radiotherapy is begun. The palliative care team is asked to see the patient as part of his visits to the oncologist's office. Recommendations for symptom control are made, accepted, and monitored. The social worker meets with the family and schedules ongoing sessions with the wife and children. The chaplain coordinates the response of the patient's pastor. Pain control is improved, and there is less tension at home. The case is discussed at the weekly palliative care team meeting to coordinate all aspects, and the oncology nurse also participates. The managing oncologist appreciates commiserating with the palliative medicine physician in the staff lounge between patient appointments.

[23], a number of well-regarded textbooks are now available, and a consensus on palliative care clinical practice guidelines has been published [24].

GRADUATE MEDICAL EDUCATION

Formal fellowship programs of at least 1 year in length are expanding rapidly. For the academic year 2000–2001, there were 17 active palliative medicine fellowship programs of at least a year in length [25]. By February 2004, the number of fellowship programs in operation or in formation had increased to 46 [26], including 6 programs funded by the Veterans Administration (VA). The VA program, which is interdisciplinary, adds up to 12 additional slots for physicians wishing advanced training in palliative medicine.

Recognizing that the rapid development of fellowship programs would benefit from the development of common standards, the American Board of Hospice and Palliative Medicine (ABHPM) and

CASE REPORT 3 Tertiary Palliative Care

A 23-year-old football athlete develops metastatic unresectable sarcoma with excruciating crescendo pain. He has regressed and is very dependent on his parents. His parents feel guilty thinking that, by permitting him to pursue college football, their decision caused the cancer to occur and spread. Experimental chemotherapy and radiotherapy are contemplated, but his performance status is too poor because of the pain.

The patient is admitted to the acute palliative care unit, where an experimental intrathecal approach to pain management is successful. High-dose opioids are weaned. During the admission, the palliative care team works intensively with the patient and his family to help with the psychological, social, and spiritual aspects of the case so that the discharge will be successful. Several family meetings are held. The palliative medicine fellow rotating on the unit develops a collaborative working relationship with the patient's oncology fellow. The patient's performance status improves to an ECOG/Zubrod score of 1, and he is eligible for study. The two fellows decide to jointly publish the case report and collaborate on writing a new clinical trial.

the American Academy of Hospice and Palliative Medicine (AAHPM) jointly established a process for accrediting training programs. The initial step in this process was a consensus process for developing voluntary standards for training [8]. ABHPM and AAHPM appointed a seven-member committee, called the Palliative Medicine Review Committee (PMRC), to implement the standards via an accreditation process. PMRC is closely modeled after the ACGME's RRCs, began accepting accreditation applications in the fall of 2003, and plans to issue accreditation decisions in 2004 [27].

BOARD CERTIFICATION

The need for a specialty board was recognized early in the 1990s by the leadership of AAHPM, which encouraged a small working group of palliative medicine physicians to plan a board that would establish and measure the level of knowledge, attitudes, and skills required for certification of physicians practicing hospice and palliative medicine. This board, ABHPM, was incorporated in 1995. It swiftly established the criteria for entry

into the field via an experiential track and gave its first examination in 1996 [7].

Eligibility for certification is now granted via two tracks: experiential and fellowship. Eligibility via the experiential track requires candidates to meet criteria related to education, training, experience, competence, and professional standing. Candidates who meet these requirements are permitted to sit for the certification examination. The fellowship track is open to fellows who have completed a year-long fellowship in hospice and palliative medicine. The fellowship director of the training program must demonstrate that the fellowship substantially meets the voluntary standards for training in palliative medicine. As ACGME accreditation of training is put in place, the board will gradually close the experiential eligibility track. Eventually, only fellows from accredited programs will be allowed to enter certification through the fellowship track.

After 7 years, over 1,500 physicians have met the qualifications for certification in hospice and palliative medicine. Most of the candidates have entered the certification process through the experiential track. As fellowship training in palliative medicine has become available, more candidates each year claim eligibility to the board via a fellowship in hospice and palliative medicine.

Candidates for the examination are required to have certification by a member board of the ABMS. Overall, 55% of candidates applying for certification reported internal medicine as their primary board, and 23% reported family practice, followed by anesthesiology, neurology, psychiatry, surgery, and radiation oncology. The most prevalent group of subspecialists seeking certification are oncologists, followed by geriatricians.

PROFESSIONAL ASSOCIATION

About half of the physicians certified by ABHPM also belong to AAHPM, the professional association for physicians in palliative medicine. AAHPM currently has 1,495 physician members, 623 of them certified by ABHPM as of January 2003 [27].

PRACTICE PATTERNS

Opportunities for the clinical practice of palliative medicine are expanding rapidly. The National Hospice Palliative Care Organization (NHPCO) states that the number of hospice programs has grown from approximately 2,000 in 1993

to over 3,200 in 2002 [28]. Medicare-certified hospices are required to have a paid or volunteer staff medical director, and NHPCO recently began an initiative to encourage member hospices to strengthen the role and competency of hospice medical directors [29]. Interest in hospital-based palliative care programs is also growing. The Center to Advance Palliative Care states that 800 hospitals now offer palliative care services and that the number appears to be increasing by about 20% annually [30]. The Center for Health Workforce Studies, State University of New York at Albany, documented that physicians currently working within palliative medicine support formal recognition of the field [31].

What Is the Likely Path for Recognition?

The American Board of Internal Medicine and the American Board of Family Practice are the two most likely sponsoring “parent” boards for the palliative medicine subspecialty. These boards are logical choices because their diplomates make up more than 75% of diplomates certified by ABHPM. Most subspecialties are recognized at the application of only one, or sometimes two, primary boards. For instance, medical oncology and hematology are sponsored by internal medicine.

A small number of physicians from other medical specialties (such as surgery, pediatrics, radiation oncology, obstetrics, and gynecology) pursue palliative medicine as a subspecialty. ABMS bylaws provide mechanisms for diplomates of any ABMS board to become certified in a subspecialty sponsored by only one or two boards if their diplomates meet the eligibility criteria and if they receive permission from the parent board.

What Are the Remaining Challenges?

The critical challenge to any specialty or subspecialty is to clearly define the legitimate boundaries of the field. As a subspecialty, palliative medicine requires training in other fields, such as internal medicine and family practice, before someone can concentrate in palliative medicine. As with other fields, there are areas of overlap with other specialties and subspecialties. Questions oncologists might reasonably be expected to ask include:

- What would palliative medicine take away from the practice of oncology?
- Will oncologists have access?
- What would oncologists no longer be able to do?

- Will there be financial implications?

Since the subspecialty is not associated with a particular procedure or “service line,” these questions can easily be answered. There is no foreseeable effect of a palliative medicine subspecialty on the practice patterns of oncologists. The role of the subspecialist in palliative medicine is usually to consult or support the primary oncologists, rather than usurp that role. There is no agenda, expressed or implied, that all suffering and dying patients be cared for by physicians who are board certified in palliative medicine.

The broad interdisciplinary nature of palliative medicine makes it more challenging to define the boundaries of the specialty. ABHPM has deliberately chosen to make room for palliative medicine’s broad interdisciplinary foundation by not restricting entry to a few primary specialties. However, as interest grows among other specialties in improving care within their own domain, the question arises as to whether there are different eligibility or training requirements for pediatricians, surgeons, critical care physicians, emergency physicians, geriatricians, and others who wish to specialize in palliative medicine.

With the exception of pediatrics, ABHPM currently expects practitioners from any primary discipline to meet the same eligibility standards. Joint training programs that meet the requirements of both palliative medicine and other specialties or subspecialties (such as in pediatrics, geriatrics, and oncology) are likely to be developed with time.

Another challenge to the field is to build enough capacity within training programs to train the next generation of specialists. The current interest in developing training programs is heartening, but financial resources are scarce, and competition for them is strong. Once ACGME recognition is achieved, the potential for federal funding of palliative medicine training will be established, which will yield significant new financial resources for the field. As fellowship training develops, training directors are working creatively to develop pathways for training of the mid-career physician, who brings to the field of palliative medicine practice experience that is rarely found in recently trained physicians. That maturity likely will continue to be an asset to the field and should not be choked off when formal fellowships become a requirement for entry into the field.

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