

Evolving the Palliative Care Workforce to Provide Responsive, Serious Illness Care

Arif H. Kamal, MD, MHS; Jennifer M. Maguire, MD; and Diane E. Meier, MD

Two hospitalists recently discussed a patient admitted for advanced emphysema. The patient had full code status, showed limited understanding of his condition, and was readmitted frequently. The hospitalists previously attempted to discuss goals of care, but they felt unsuccessful and cited time constraints and hesitancy with facilitating the complex goals of care discussions. One physician said to her colleague, “Where I trained, we could consult palliative care to help with complex patients. Our position for a palliative care specialist remains unfilled after 2 years. When will we get some help?”

This situation is 1 example of a national crisis in providing accessible, responsive palliative care. Palliative care is specialized medical care; it is appropriate for patients of any age with any stage and type of serious illness, whether the goal is to cure illness (for example, a person aged 25 years with acute leukemia), prolong life during chronic disease (for example, heart failure), or focus primarily on quality of life (for example, advanced pancreatic cancer).

Palliative care comprises 2 dominant delivery mechanisms. The first, termed “primary” or “generalist” palliative care, includes primary care and medical specialists (for example, oncologists or pulmonologists) delivering supportive care to persons with serious illness. Then, when needed, fellowship-trained palliative care clinicians provide concurrent care for patients requiring greater skill. This approach (“secondary” or “specialty” palliative care) comprises a growing specialist-level practice for clinicians completing palliative care fellowship (1). Specialist palliative care has become a part of everyday health care, with 6 million patients annually receiving hospital-based consultative services (2).

Recognition of palliative care’s benefits has propelled a rapid expansion of specialty palliative care teams. Estimates based on data from the American Hospital Association suggest that 66% of hospitals (>50 beds) have a specialist palliative care program—an almost 150% increase in the past decade (2). Despite such growth, around one third of hospitals (about 1700) lack access. Further, inconsistent availability of palliative care in outpatient and community settings hinders timely provision of supportive care to patients with acute but predictable crises, leading to emergency department visits and hospitalizations.

The most straightforward solution to address inadequate access is to continue the remarkable growth. However, 3 key challenges remain. First, there is a current shortage of an estimated 18 000 physicians to meet hospital consultation needs alone (3). This does not count the physician workforce needed to staff nurs-

ing homes, office practices, and other community-based care settings. The current workforce consists of 6600 board-certified palliative care physicians (4), or an estimate of 1 board-certified physician for every 20 000 persons with chronic illness (5). Second, approximately 15% of palliative care fellowship slots are unfilled, and on average, 265 fellowship-trained palliative care physicians enter the workforce annually (6). Third, a recent survey of palliative care clinicians reported that almost half intend to leave the field by 2023, which reflects both those nearing retirement and high levels of burnout among younger physicians (7).

So what can be done? In *Philosophical Dictionary*, Voltaire famously wrote that “perfection is the enemy of the good.” In our opinion, there will never be enough fellowship-trained palliative medicine specialists to support the rapidly expanding number of Americans in need. Additional fellowships funded by an exemption to the cap on graduate medical education-funded slots would help, but this will not be sufficient to meet the demand. A more practical and immediate solution is needed.

We recommend an alternate midcareer certification pathway to build the specialty workforce. This would activate clinicians wanting to work in palliative care but who cannot sacrifice the time and money necessary to complete a fellowship. These midcareer “palliative care champions” would bridge the gap between primary and secondary palliative care delivery mechanisms. Participants would have intensive advanced training that combines didactic (content) knowledge and bedside experience (skill) with continuous evaluation to ensure proficiency and quality. They would do palliative care consultations when board-certified clinicians are not available, review cases with board-certified colleagues, and participate in continuous and self-paced education. This cooperative process between champions and board-certified physicians mirrors an approach described by the Mayo Clinic (8), resembles the case-review evaluation process common to surgical specialties, and leverages the collaborative style inherent to the field.

This approach has several advantages. First, it is feasible. Several existing programs offer intensive multiday palliative care didactic and bedside training courses for clinicians of all disciplines. These programs have shown consistent growth in attendance. Second, it is an accepted approach. Experienced physicians without fellowship training comprise 75% of the current workforce (9) because they entered during the grandfathering period. In addition, recent approval of a hospice medical director certification reflects further ac-

ceptance that clinicians can successfully deliver high-quality end-of-life palliative care to the 1.5 million Americans served annually by hospice care (10) without additional fellowship training. Third, it safeguards consistent delivery of quality palliative care. Health systems currently employ physicians not board-certified in palliative care to provide palliative care consultations (9). Health systems can use this approach because, regardless of training or board certification, any clinician can be reimbursed for practicing palliative care by billing common symptom or function International Classification of Diseases, Ninth Revision, codes (for example, 338.3 for cancer pain or 799.3 for debility); palliative care-specific codes (such as V66.7) are not reimbursed by Medicare and many payers. A recent survey estimates that at least 5% of practicing palliative care physicians are not fellowship-trained or board-certified (9). As the demand for palliative care increases, we believe this practice will grow. A structured program to educate and evaluate such palliative care champions will ensure consistent services across settings. Fourth, many will probably participate. We anticipate robust demand from midcareer physicians who cannot participate in fellowship training and certified hospice medical directors seeking to expand their clinical roles.

With the unprecedented expansion of the population with serious or advanced illness comes the professional responsibility to deliver on the proven benefits of palliative care to more patients who currently have limited access. Further, the urgency of this workforce crisis applies to all members of the interdisciplinary team and not just physicians. We call on the certifying boards to show the flexibility and capacity to evolve certification requirements so that patients' needs are met. If this is not addressed, the conversation between our hospitalists will be an ignored early warning signal of a health care system in crisis instead of an opportunity to improve access to high-value palliative care for all persons in our country.

From Duke Cancer Institute, Durham, North Carolina; University of North Carolina School of Medicine, Chapel Hill, North Carolina; and Icahn School of Medicine at Mount Sinai, New York, New York.

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Requests for Single Reprints: Arif H. Kamal, MD, MHS, Duke Clinical Research Institute, 2400 Pratt Street, Room 8043, Durham, NC 27710; e-mail, arif.kamal@duke.edu.

Current author addresses and author contributions are available at www.annals.org.

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Current Author Addresses: Dr. Kamal: Duke Clinical Research Institute, 2400 Pratt Street, Room 8043, Durham, NC 27710.
Dr. Maguire: Division of Pulmonary Diseases and Critical Care Medicine, University of North Carolina School of Medicine, CB 7020, 130 Mason Farm Road, 4th Floor Bioinformatics Building, Chapel Hill, NC 27599.
Dr. Meier: Center to Advance Palliative Care, Icahn School of Medicine at Mount Sinai, Annenberg Building, 1468 Madison Avenue, New York, NY 10029.

Author Contributions: Conception and design: A.H. Kamal, J.M. Maguire, D.E. Meier.
Drafting of the article: A.H. Kamal, J.M. Maguire, D.E. Meier.
Critical revision of the article for important intellectual content: A.H. Kamal, J.M. Maguire, D.E. Meier.
Final approval of the article: A.H. Kamal, J.M. Maguire, D.E. Meier.
Collection and assembly of data: A.H. Kamal.