Dear Editor:

I’m always thrilled, and a little surprised, when surgeons request that I perform a palliative care consult on one of their patients. They rarely ask. But there it was, Monday morning and my pager displayed the surgery resident’s callback number.

Palliative care physicians don’t usually have access to surgical patients, yet oftentimes their patients are the ones who need us the most given the impact of surgery and its initiating traumas or illnesses. Yet surgical culture does not tend to prioritize palliative approaches. Although a debunked myth, many still see pain as a helpful diagnostic tool, not to be masked. Breaking bad news makes some feel defeatist and weak, many still see pain as a helpful diagnostic tool, not to be masked. Palliative care physicians don’t usually have access to surgical patients, yet oftentimes their patients are the ones who need us the most given the impact of surgery and its initiating traumas or illnesses. Yet surgical culture does not tend to prioritize palliative approaches. Although a debunked myth, many still see pain as a helpful diagnostic tool, not to be masked. Breaking bad news makes some feel defeatist and weak, many still see pain as a helpful diagnostic tool, not to be masked.

Rebecca, the chief resident, was an excellent surgeon, tough and assertive. But she was unusual in that she was a strong supporter of palliative care, despite the cultural dissonance of the two specialties. And so whenever she was on service, we got requests to consult on their most challenging cases.

An 80-year-old man had fallen off a ladder with scans suggestive of diffuse axonal injury. He had been ventilated in the intensive care unit (ICU) for several weeks. “Nobody in this family is willing to make a decision about life support, even though everyone agrees he wouldn’t want to live this way,” she lamented.

As we stood there, Rebecca’s attending walked in. “I called the palliative care team in to talk about our guy,” she told him. “I thought they could help us with this family.”

He stepped back and folded his arms. “Palliative care, huh?” He stroked his chin jokingly. “You here to give me a massage?” Rebecca flushed in embarrassment at his quip.

Despite our efforts, this case didn’t end well. But Rebecca continued to consult us often and became a regular attendee at ethics committee meetings. A few months before she was scheduled to leave for her fellowship training, she came to me for advice. With a sigh, she said, “I really feel like I need to do a palliative care fellowship. But I’m already a PGY-7.”

It made total sense. She was starved for community as evidenced by her attending’s dismissive behavior. Attitude rolls down hill. Many of her colleagues wouldn’t have given the 80-year-old man a second thought, would have shrugged their shoulders and put in their tubes. But she took the case all the way to the ethics committee, and still thinks about it to this day. How depressing to start her career feeling as though she were a misfit. And yet how ridiculous, I thought, to have to complete another entire fellowship in order to practice what all surgeons, indeed all doctors, should be practicing—patient-centered care.

Rebecca was a surgeon. She wanted to operate. She wasn’t interested in managing the most esoteric of symptoms. She would be happy to call a palliative care consult for that. “Eighty percent of what I need to learn is how to break bad news,” she told me.

Rebecca is one of several young subspecialty doctors I know who feel frustrated by the traditional approaches of many of their peers, and believe the only remedy is to complete a palliative care fellowship. The nephrologist who does consults in our ICU and confesses her despair to me when she is called in to perform dialysis at the end of a patient’s life. The young emergency room (ER) doctor who told me he doesn’t want to keep processing dying patients like a grocery bagger, lining them up and sending them to the ICU. These physicians are yearning for something they haven’t yet found in their training.

And so Rebecca, a young mother, already in substantial debt from her training, was considering taking a year out, following the whims of “the match,” putting a hold on paying back her loans, maybe moving out of state, possibly losing the job waiting for her, all in order to become a card carrying palliative care physician.

I am a card carrying palliative care physician and it has been a transformative experience for me. But having been grandfathered in at an earlier time before fellowship training was required, I didn’t have to turn my life around to do it.

Yet as appreciative as I am of palliative care, I feel I must strike a cautionary note about our attitude towards it. In its meteoric ascent since its official acceptance into the American Board of Medical Specialties in 2006, palliative care has essentially become the go-to specialty for patient-centered care at the end of life. The risk here is that we are lulled into thinking that we have the solution, and all we need to do is invest more in palliative care.

And for this, I believe patients will suffer. Why? Because there can never be enough palliative care physicians to attend to the needs of all dying patients. Moreover, even if there was a ratio of one palliative care doctor to every needy patient, it would still be hard to get palliative care consultation to those patients who are managed by those subspecialists critical of palliative care. The cultural divide is still too great. Last, and certainly not least, why should nonpalliative care doctors be let off the hook from being patient-centered themselves?
Patient centeredness should not just be under the jurisdiction of palliative care; rather, it should be deeply embedded in the core principles of every branch and twig of medicine. We should all be practicing patient-centered medicine all the time. We must require every doctor to flex these muscles. If physicians simply depend on the palliative care team to swoop in as a last resort when they are out of curative options, they aren’t learning those skills themselves. Indeed, they aren’t even learning how to recognize the need for such a consult.

Subspecialists in particular—those who do things to people—should be patient centered, and yet most of them can’t or won’t take the time to complete a palliative care fellowship. And so I am concerned that by making palliative care the only game in town for patient centeredness we are not integrating its key principles into the rest of medicine.

And so where does that leave Rebecca, and the young ER resident, and the frustrated nephrologist?

I propose a new society, the American Society for Patient-Centered Physicians (ASPCP). Its purpose would be to bring together physicians of all specialties whose treatment philosophy prioritizes patient-specific rather than specialty-specific approaches. Communication, discussing goals of care, weighing benefits and burdens of treatment options, and managing pain and distress would be lauded as essential elements of patient care, at least as important as performing procedures and prescribing disease-specific therapies.

The ASPCP would sponsor the creation of individualized, patient-centered training curricula for all varieties of residency programs. Its members would help develop protocols and standards for patient-centered practice in their own fields. There would be annual meetings, CME, quality initiatives and position papers. Its growing representation across the various fields would begin to change the entire culture of medicine, leaving no specialty exempt from focusing primarily on the patient, not the procedure. Its members would find the camaraderie they are thirsty for, and be inspired and empowered to continue to push for change, even when they are feeling most isolated.

Most importantly, it would help us give our patients what they need.

“You don’t need to do a palliative care fellowship,” I said to Rebecca. “What you need is to become the best surgeon that you can be, which includes becoming skilled at breaking bad news. It means being compassionate, logical, honest, and brave. That,” I said, “is why you became a doctor in the first place. So get to it.”

The American Society for Patient-Centered Physicians. Who’s in?

References


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