

Development of a Medical Subspecialty in Palliative Medicine: Progress Report

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ABSTRACT

There is significant interest in seeking professional recognition of expertise in caring for people with serious life-threatening illness and their families through creation of a specialty in palliative medicine. Certification of physicians and accreditation of training programs are key elements for formal recognition. The American Board of Hospice and Palliative Medicine was established to achieve these goals. The next step in the maturation of the subspecialty of palliative medicine is to have both the certification and the accreditation recognized by the professional self-governing bodies in organized medicine. This paper answers common questions about obtaining recognition by the Accreditation Council of Graduate Medical Education, the American Board of Medical Specialties and its member boards. Formal recognition of the subspecialty of palliative medicine is sought in order to extend the knowledge and skills inherent in the domains of palliative medicine. Such recognition will also encourage more physicians to enter the field and assure standards of care for those patients and their families who need it.

INTRODUCTION

ALTHOUGH THE SPECIALTY of palliative medicine has been formally recognized in Great Britain, Ireland, Australia, and Canada, it is still a developing specialty in the United States.¹ In this paper, we answer common questions that arise as we pursue formal recognition of palliative medicine as a subspecialty by organized medicine.

WHY IS A FORMALLY RECOGNIZED SUBSPECIALTY IN PALLIATIVE MEDICINE NEEDED NOW?

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:

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- Relief of suffering,
- Promotion of quality of life for patients and families in the context of life-threatening illness, and
- Promotion of the development and growth possible at the end of life.

The disciplined application of these competencies is necessary to improve the health and health care 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.

The medical knowledge needed to relieve suffering and improve quality of life is greater now than in it has ever been in the history of medicine. Yet consistent application of this knowledge is not yet routine. A 1997 report from the Institute of Medicine (IOM) highlighted deficiencies in the health care 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 in U.S. health care.² The IOM report recognized the benefits formal recognition of palliative medicine would confer, stating that a formal specialty would:

- 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.

Palliative medicine needs to be integrated throughout the care system.³ Primary palliative care is the responsibility of all physicians. This includes basic approaches to the relief of suffering and improving quality of life for the whole per-

son and his or her family. Secondary palliative care is the responsibility of specialists and hospital or community based palliative care or hospice programs. The role of the secondary specialist or program is to provide consultation and assist the managing service. Tertiary palliative care is the province of academic centers where new knowledge is created through research, and new knowledge is disseminated through education. In addition, tertiary palliative care centers are likely to care for the most challenging cases.

The need for palliative care at the end of life has been reinforced in concurring opinions from the U.S. Supreme Court that refused to recognize a constitutional right to assisted suicide.⁴ The American College of Physicians and the American Board of Internal Medicine (ABIM) have both called for general physician competency in the care of persons with terminal illness.^{5,6} Efforts are also underway to improve the skills of practitioners and to introduce palliative medicine training into physician education.⁷⁻¹¹

With recognition of the need to redress deficiencies in the care provided by generalists, the time is propitious to establish subspecialty certification for physicians working in palliative medicine. Subspecialists are needed to provide advanced care for patients and families whose needs exceed the capabilities of generalist or other specialist physicians. Subspecialists also have larger responsibilities to the field. They provide training and education, spearhead quality improvement initiatives and undertake the research that will ultimately yield the evidence on which general medical practice should be based.

HOW DOES FORMAL RECOGNITION LEAD TO IMPROVED CARE?

Formal recognition of a specialty by organized medicine sets standards on which the public can rely. Formal recognition also represents the judgment of knowledgeable peers that a field is worthy of pursuit. Thus a recognized field can 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.

Highly skilled specialists will be available to help with the most difficult patients and support their colleagues in improving care for all patients.

ARE THERE RISKS ASSOCIATED WITH FORMAL RECOGNITION?

Creation of another subspecialty does carry risks. Subspecialization can further fragment health care and drive up costs by adding yet another round of specialist consultations. Additionally, some are concerned that other physicians will “dump” responsibility for palliative medicine exclusively into the lap of the specialist, when what patients desire and need is continuity with their primary attending physician. Alternatively, there may be a risk of alienating physicians already doing good palliative care, but not identifying or practicing as palliative medicine. Proponents of a palliative medicine subspecialty address these concerns through careful delineation of the appropriate collaborative relationship between the consulting specialist and the primary attending physician.

An additional concern is that the development of a subspecialty will lead to physician domination of a field that values interdisciplinary team care using a bio-psycho-socio-spiritual model. Some also worry that widespread dissemination of palliative care throughout the health care system will lead to a dilution or co-option of some essential essence of good palliative care. For instance, skeptics fear that hospital-based palliative care services—because of the culture inherent in hospitals—will be less likely to help patients return to their own homes and will be more likely to overuse diagnostic tests and procedures. Finally, some predict that the emergence of a cadre of academic palliative medicine specialists will engender a town-grown rift between community-based clinicians (primarily hospice medical directors—often part-time and often, currently, volunteer or virtually volunteer) and fellowship-trained specialists practicing within the academic medical center.

While we note these concerns, they are neither unique to palliative medicine nor inevitable. Subspecialization *per se* neither increases nor decreases the likelihood of these outcomes occurring. The root causes for these potential problems must be sought and prevented or redressed. They

do not mitigate the driving rationale for professionalization of a field of new knowledge and practice of importance to the health of the public.

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.”¹²

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.”¹³

ACGME sponsors a Residency Review Committee (RRC) for each of the 26 specialties that it accredits. Each RRC develops and administers the accreditation standards for its primary specialty and for the subspecialties within the primary specialty. RRCs are 6- to 15-member vol-

unteer committees sponsored by the applicable medical specialty board, the American Medical Association and, in many instances, an appropriate major specialty organization. This links each RRC to the interests of the specialty even while ACGME retains an overall coordinating function across the RRCs. RRC staff are employees of ACGME and RRCs are centrally coordinated and financed by ACGME.

In contrast to ACGME's central control of RRCs, ABMS is a confederation of independent boards, which formed independently and then applied for membership.^{14,15} Subspecialties may also arise independently and later be "adopted" by a parent board that is a member of ABMS. Alternatively, an ABMS primary board may create a new subspecialty certification in response to growth and change within the area of its specialty.¹⁶

Membership in ABMS and accreditation of training by ACGME are what define "formal recognition" of a specialty. The benefit of recognition through ACGME accreditation is very tangible: Medicare funding of residencies 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 only allow physicians to publicly advertise board certification 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.

The establishment of certifying boards within the profession to create standards for training and competency and the means to assess them, is a relatively recent phenomenon in the history of medicine. The concept of a specialty board was first proposed in 1908 when the American Academy of Ophthalmology and Otolaryngology suggested that practitioners undertake a specific educational program and pass an examination given by senior members of a discipline (a board). The first board, ophthalmology, was incorporated in 1917, requiring 2 years of specialty preparation and successful completion of an exam to earn certification. In addition, the Board prepared lists of approved institutions and preceptors

deemed competent to give the required instruction.¹⁴

By 1933 it was suggested that national standards for recognizing specialists be established using the mechanisms of specialty boards. The Advisory Board of Medical Specialties was formed to serve as a forum for discussion among specialty boards.¹⁴ In 1970 this group was reorganized as the American Board of Medical Specialties (ABMS). Each constituent board of ABMS was first formed in response to the need to set standards of professionalism within a specialty.

Although ABMS is the most important coordinating structure for certification and accreditation, it has not fully met the need for procedures that establish standards for skills, knowledge, and training of physicians. Currently there are more than 125 boards lying outside of the member or "parent" boards of ABMS. By and large, they have been established to set standards of professionalism for a group of physicians with special expertise that exceeds that reasonably expected of the general practitioner or other subspecialists. Although there are those who decry the fragmentation and subspecialization of medicine, this trend represents a response to rapid increases in medical knowledge as well as the professional need to set standards for practice and for training.

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 cardiology) (17). Palliative medicine requires initial training 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. The process for recognizing a new specialty board is more

stringent than the process for recognizing a subspecialty. The newest boards admitted to ABMS were Medical Genetics in 1991 and Emergency Medicine in 1979.

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 LCSB consists of four voting representatives from the ABMS Executive Committee and four voting representatives from the AMA/CME. LCSB meets annually and is charged with determining whether an application meets the criteria set for boards, as spelled out in a document, jointly approved by ABMS, CME/AMA, and the AMA House of Delegates, called the "Essentials For Approval Of Examining Boards In Medical Specialties."¹²

The current version of the "Essentials" establishes the following criteria for approval of new examining boards:

- A. 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.
- B. 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, gender, 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.
- C. 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.
- D. 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 AGME 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. The primary board presents the application for a new subspecialty to the Committee for Certification, Subcertification and Recertification (CO-CERT). 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 is as follows:

1. A group wishing to have a new discipline recognized provides specified information to ACGME to support the need for the new area.
2. ACGME establishes an ad hoc committee to review the petition for new specialty training. The Chair of ACGME appoints the ad hoc committee with the concurrence of the Executive Committee.
3. The ad hoc committee recommends one of three actions: (1) denial; (2) referral to an existing RRC for consideration for inclusion in the current discipline or to be considered as a new subspecialty of the existing general discipline; or (3) recommended for "Preliminary Development" as a new discipline.
4. In cases where a proposal is referred to an existing RRC but embraces elements of other existing RRCs, the involved RRCs may establish a joint working group to assess and recommend the appropriate committee structure for the new area.

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:

1. That the board awards a certificate in the subspecialty and supports accreditation in that area; or,
2. That the board does not intend to award a cer-

tificate at this time but is not opposed to the RRC beginning to accredit programs in the subspecialty; or

3. That the board is opposed to the accreditation of programs.

The informal process that accompanies the formal approval procedure plays an important role in eventual approval or disapproval of applications. Using the formal criteria requires the exercise of professional judgment, which can be appropriately shaped and influenced by building relationships and providing ample information and dialogue about the significance of the application. In this way, applicants may be able to anticipate the concerns or objections of the voting parties before their application is considered and thereby proactively address those concerns. In essence, there is an informal political or community organizing aspect that is as important as the formal written application and public committee votes outlined in the written procedures.

WHY IS PALLIATIVE MEDICINE NOT BEING CONSIDERED AS A CERTIFICATE OF ADDED QUALIFICATION RATHER THAN A SUBSPECIALTY?

The ABHPM understands that the ABMS decided that no further certifications of added qualification 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, we have made significant strides toward meeting the requirements for formal recognition.¹⁷ 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. The devotion of an entire issue of the *Journal of the American Medical Association* solely to end-of-life care

in 2000 signaled the interest of the wider medical community in this field.¹⁸

Publication of scholarly research

The emergence of specialized journals, well-regarded textbooks, and formal curricula are all indicators 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), and *European Journal of Palliative Care* (United Kingdom). More than one curriculum for palliative medicine has been published.^{19,20} Models to guide clinical palliative care have been disseminated²¹ and a number of well-regarded textbooks are now available.

Graduate medical education

Formal fellowship programs of at least one 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,²² while by August 2003, there were 43 fellowship programs in operation or in formation.²³ These include 6 programs funded by the Veterans Administration. 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, ABHPM and 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.²⁴ 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 ACGME's RRCs and plans to accept accreditation applications for the first time in the fall of 2003, with accreditation decisions issued in 2004.

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 1996.¹⁷

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 one-year 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, more than 1200 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 becomes available, a few candidates have gained eligibility to the board via a fellowship in hospice and palliative medicine.

Candidates for the examination are required to have another ABMS certification. Overall, 55% reported internal medicine as their primary board, while 23% reported family practice, followed by anesthesiology, neurology, psychiatry, surgery, and radiation oncology.

Professional association

Approximately half of the physicians certified by ABHPM also belong to AAHPM, the professional association for physicians in palliative medicine. AAHPM currently has 1495 physician members, 623 of them certified by ABHPM as of January 2003 (Anne Cordes, personal communication).²⁵

Practice patterns

Opportunities for the clinical practice of palliative medicine are expanding rapidly. The National and Hospice Palliative Care Organization (NHPCO) states that the number of hospice programs has grown from approximately 2000 in 1993 to over 3200 in 2002.²⁶ 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.²⁷ 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 the number appears to be increasing by approximately 20% annually.²⁷ The Center for Workforce Studies at the State University of New York documented that physicians currently working within palliative medicine support formal recognition of the field.²⁸

WHAT IS ABHPM'S STRATEGY FOR ACHIEVING THE GOAL OF RECOGNITION?

With the concurrence of the professional association (AAHPM), ABHPM has set a strategic goal of achieving formal recognition for the field of palliative medicine. ABHPM believes that ABMS recognition and ACGME accreditation will lead to the strongest implementation of standards for training and practice in palliative medicine, ultimately helping to sustain improvements in the field. ABHPM proposes subspecialty status for palliative medicine rather than primary specialty status because the knowledge and skills needed in palliative medicine are acquired after first solidifying clinical skills in one of the primary clinical specialties.

ABHPM is looking to internal medicine and family medicine as the two most likely sponsoring 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, cardiology is sponsored by internal medicine. Geriatrics is sponsored by both internal medicine and family practice.

We recognize that a small number of physicians from other medical specialties (such as surgery, pediatrics, obstetrics and gynecology) pursue palliative medicine as a subspecialty. It is ABHPM's goal to preserve this access after formal recognition. ABMS reports that mechanisms exist for diplomates of any ABMS boards to become certified in a subspecialty sponsored by only one or two boards if their diplomates meet eligibility criteria and if they receive permission from the parent board. Alternatively, a conjoint board structure could be developed to accommodate the need to preserve access of diplomates in multiple primary boards to the subspecialty.

ABHPM's strategy for achieving recognition has several components:

1. Work collaboratively with AAHPM, fellowship directors, and other interested groups to achieve recognition. Clearly and transparently delineate the different roles of the various organizations. For instance, ABHPM has the role of establishing the standards for entry into the field. AAHPM has the broader role of advocating for physicians and other clinicians working in the field, providing education to various levels of practitioners, and encouraging the overall growth of the field.
2. Build a strong certification program, including maintenance of certification. Exemplify excellence in all components of the program, from the administration of eligibility standards through the development and administration of the examination. Keep the certification program attractive and valuable to physicians, employers, health care institutions, and the public.
3. Build an identifiable cadre of certified diplomates who remain committed to the field, continuing their own skill development and contributing to the education and training of others. The initial cadre of diplomates entered the field during the "grandfathering period" by meeting eligibility requirements for the experiential track. Gradually these experiential requirements are expected to evolve. In the long run, the experiential track will be discontinued and formal training will be required prior to sitting for certification. This will likely occur after formal recognition.
4. Stop offering waivers to applicants who have no ABMS certification in a specialty area after 2005. This does not mean that fellowships are required beginning in 2005. ABHPM made this decision to further position us for recognition by meeting existing ABMS standards.
5. Conduct accreditation of fellowship programs with the expectation that the accreditation process will be turned over to the ACGME relatively quickly.
6. Participate in the "informal" application process to ABMS and ACGME by opening lines of communication with leaders in other interested fields. Discuss the concerns that other boards may have about the formalization of this new subspecialty and address these concerns straightforwardly. Find one or more "parent" boards willing to host the subspecialty and champion a formal application before the ABMS.
7. Submit formal written applications to ACGME and to ABMS (through one or more of its member boards.)

WHAT ARE THE REMAINING CHALLENGES?

The critical challenge to any specialty of 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 focus in palliative medicine. As with other fields, there are areas of overlap with other specialties and subspecialties. Delineating and negotiating those boundaries is as much a political as it is an intellectual exercise. As with any new field, questions by existing specialties could be expected to include: What would palliative medicine take away? Will our diplomates have access? What would our specialists no longer be able to do? Will there be financial implications? ABHPM is working to address those questions by talking forthrightly with other fields about their concerns. In these conversations, board representatives have emphasized that the role of the specialist in palliative medicine is usually to consult or support the primary attending physician, rather than usurp that role. There is no agenda, expressed or implied, that all suffering and dying patients be cared for by physicians 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 by 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, etc., 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, 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 is 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 practice experience to the field that is rarely present 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.

ACKNOWLEDGMENTS

The Trustees of the American Board of Hospice and Palliative include: Charles F. von Gunten, M.D., Ph.D., Chairman (San Diego Hospice and Hematology/Oncology, University of California, San Diego); Russell Portenoy, M.D., Vice Chairman (Pain Medicine and Palliative Care, Albert Einstein Medical School); Cheryl Arenella, M.D., Secretary (Family Practice, Hospice of Northern Virginia); Paul Sloan, M.D., Treasurer (Anesthesiology, Pain Medicine University of Kentucky); Bob Arnold, M.D., (Palliative Care and Medical Ethics, University of Pittsburgh Medical School); Susan Block, M.D., (Adult Psychosocial Oncology Program, Dana-Farber Cancer Institute and Brigham and Women's Hospital); Lyla Correoso, M.D., (Medicine, Montefiore Hospital); Kathleen M. Foley, M.D., (Memorial Sloan-Kettering Can-

cer Center); Joan Harrold, M.D., M.P.H., (Hospice of Lancaster County); Clark Kerr, (21st Century Consumer); Jean Kutner, M.D., (University of Colorado Health Sciences Center); John Mulder, M.D., (Alive Hospice); Karen S. Ogle, M.D., (College of Human Medicine, Michigan State University, East Lansing); Philip H. Santa-Emma, M.D., (Mount Carmel Hospice and Palliative Care Services).

The authors wish to thank Dr. David Leach, Executive Director of the Accreditation Council for Graduate Medical Education; Dr. Stephen Miller, Executive Vice President of the American Board of Medical Specialties; Dr. Lee Dockery, Former President, American Board of Medical Specialties; and Dr. Benson Munger, former Executive Director of the American Board of Emergency Medicine for their advice and encouragement.

This work has been supported by generous funding from The Robert Wood Johnson Foundation and the Project on Death in America.

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GLOSSARY OF ACRONYMS

AAHPM American Academy of Hospice and Palliative Medicine

The professional membership association for physicians interested in hospice and palliative medicine.

AAMC Association of American Medical Colleges

The AAMC is a non-profit association whose members are US medical schools, Canadian medical schools, major teaching hospitals and health systems, academic and professional societies, as well as many individuals involved in medical education. Its primary purpose is to advocate for and improve medical education. The AAMC is a sponsor of ACGME and an associate member of ABMS

ABFP American Board of Family Practice

The certifying board for physicians in family practice.

ABHPM American Board of Hospice and Palliative Medicine

The certifying board, established in 1995, for physician specialists in hospice and palliative medicine.

ABIM American Board of Internal Medicine

The certifying board for internal medicine physicians.

ABMS American Board of Medical Specialties

The ABMS is an organization of the 24 ABMS approved medical certifying boards and six associate organizational members. Its primary purposes are to approve new medical specialties and subspecialties and to advocate for its member boards. The ABMS is a sponsor of ACGME.

ACGME Accreditation Council for Graduate Medical Education

The ACGME is a council of five sponsoring organizations and is responsible for the accreditation of post-MD medical training programs within the United States. A parallel organization is responsible for accreditation of osteopathic medical programs. The sponsoring organizations of ACGME include, ABMS, AHA, AMA, AAMC and CMSS.

AHA American Hospital Association

The AHA is the primary hospital membership association for hospitals in the United States. It represents nearly 5000 hospitals, health care systems, networks and over 37,000 individual members. The AHA is a sponsor of ACGME and an associate member of ABMS.

AMA American Medical Association

The AMA is a broad-based member association composed primarily of individual physicians in the United States. The AMA has a wide ranging series of programs and projects related to their members. They are a leading medical advocacy organization. The AMA is a sponsor of ACGME, an associate member of ABMS and a sponsor of many RRCs.

AMA/CME American Medical Association/Council on Medical Education

The AMA/CME is a Council of the AMA and is primarily responsible for recommendations to

the AMA on medical education issues. Its connection to specialty approval is that it appoints members to the LCSB and also makes recommendations on LCSB decisions.

CMSS Council of Medical Specialty Societies

CMSS is a membership organization representing 20 national medical specialty societies. It has waned in influence as a number of influential medical organizations have withdrawn their membership. It is a sponsor of ACGME and an associate member of ABMS. It also makes recommendations on AMA appointments to RRCs.

LCSB Liaison Committee for Specialty Boards

The LCSB is a joint body composed of an equal number of members each from the ABMS and the AMA/CME. Its primary purpose is to review applications for new primary specialty boards and to make a recommendation to its parent organizations.

PMRC Palliative Medicine Review Committee

Committee jointly established by ABHPPM and AAHPPM to develop and implement accreditation standards for palliative medicine fellowship training.

RRC Residency Review Committee

Each specialty recognized by ABMS has an RRC that is responsible for carrying out the actual accreditation activities for training programs in that specialty including establishing program requirements and reviewing individual programs. This is done under a grant of authority from the ACGME. The committee members are appointed by the major organizations in the specialty.