EDITORIAL

Steven Z. Pantilat, MD

Palliative Care Service and Palliative Care Leadership Center, Department of Medicine, University of California, San Francisco, San Francisco, California

Palliative Care and Hospitalists: A Partnership for Hope

It is right and fitting that an article focused on palliative care appears in the inaugural issue of the *Journal of Hospital Medicine (JHM)*.[1] Both hospital medicine and palliative care are rapidly growing fields expanding in response to quality and economic imperatives. Both fields recognize the need to develop systems to care for seriously ill patients and to work within interdisciplinary teams. In fact, a natural and mutually beneficial relationship should exist between these two fields. For palliative care, hospital medicine and hospitalists offer the physicians and systems approach to care that could guarantee access to high-quality palliative care for all hospitalized patients. In addition, hospitalists offer the promise of increasing the number of hospital-based palliative care programs as the presence of a hospitalist program is strongly associated with having or starting such a program.[2,3] For hospital medicine and hospitalists, palliative care offers a compassionate and high-quality response to the challenge of caring for seriously and terminally ill patients and their families. By each embracing the other, both fields could find willing and eager partners in the quest to provide the highest possible quality of care for hospitalized patients.

In this first issue of *JHM*, Dr. Meier offers hospitalists an intriguing and attractive picture of palliative care. She describes how the growth of palliative care is driven by the needs of an ever-larger group of patients living with chronic and life-threatening illness and evidence of high quality and satisfaction for these patients who have many physical, emotional, psychological, and spiritual concerns. Dr. Meier also demonstrates how hospital-based palliative care can coordinate with hospices to provide the continuity of care for terminally ill patients that is often elusive at hospital discharge. Finally, Dr. Meier provides a practical list of resources for clinicians seeking further training in the field. No doubt hospitalists will appreciate this list as the core competencies in hospital medicine, published as a supplement to this issue of *JHM*, include palliative care, pain management, communication, and discharge planning.

As Dr. Meier states in her article "Palliative Care in Hospitals," many types of clinicians can provide palliative care in hospitals, including general internists, nurses, geriatricians, oncologists, hospitalists, and others, yet hospitalists are likely to emerge as the predominant providers of palliative care to hospitalized patients.[4] That 75% of Americans die in institutionalized settings, where hospitalists are becoming the dominant providers of care, will drive this prediction.[5] In addition, hospitalists are increasingly leading efforts in quality improvement, patient satisfaction, and patient safety.[6] Of necessity these initiatives will involve the sick-

See original article on pages 21–28, this issue.

Dr. Pantilat is a Faculty Scholar of the Project on Death in America and president of the Society of Hospital Medicine.

Supported by a K23 Mentored Patient Oriented Clinical Research Career Development Award from the National Institute on Aging (K23 AG001018-05) and by the UCSF Palliative Care Leadership Center, a program funded by the Robert Wood Johnson Foundation.

© 2006 Society of Hospital Medicine
DOI 10.1002/jhm.12
Published online in Wiley InterScience (www.interscience.wiley.com).

est hospitalized patients and will look to palliative care as a proven response for improving quality and increasing satisfaction.

Hospital medicine and palliative care have other aspects in common that make a melding of the two fields beneficial. Both fields recognize and emphasize the need for interdisciplinary care; good communication between members of the health care team and between health care providers and patients; and timely, effective, and responsible discharge planning. Finally, both fields often rely on multiple sources of funding including professional fee billing and support from the hospital for the added value that programs provide. Sharing so many issues in common should help hospital medicine and palliative care form strong links.

For these links to take hold and for the benefits of this partnership to bear fruit, members of both fields, and especially those with a foot in each, need to reach out. For hospitalists this means getting educated in palliative care, an area for which hospitalists recognize they are underprepared.[7] Each hospitalist must be able to provide primary, basic palliative care to each patient.[8] Some hospitalists will discover the rewards of palliative care and seek further training and even board certification. These hospitalists can start or join palliative care teams in their institutions. Finally, some hospitalists will become experts in palliative care and join or lead palliative care programs at tertiary care centers. In turn, palliative care providers must reach out to hospitalists. Palliative care clinicians should seek out hospitalists at their institutions and hospices should contact hospitalists at their local hospitals. These programs need to invite hospitalists to participate in the palliative care team and suggest how their services can help the patients of hospitalists. This natural alliance can come about only if both sides reach out.

A partnership between palliative care and hospital medicine will be good for patients and their families as well as for each field, as hospitalists enable realization of the goal of providing palliative care to every patient in the United States. In addition, this partnership will be good for hospitalists who embrace this work. Palliative care can connect us to the humanism and compassion that brought so many of us to medicine and can serve as an antidote to burnout. Furthermore, by caring for patients with life-threatening illnesses we remember that our time is limited and that each day is a gift. We recognize the importance of making the most of our time regardless of how long we have and of choosing carefully how and with whom we spend our time.

In this first issue of *JHM*, Dr. Meier makes a strong argument for the need and continued growth of palliative care in hospitals, lays out a strategy for achieving this growth through education and program development, and in doing so, opens the door to hope for the future. Through palliative care we can offer patients hope for healing when cure is not possible, for comfort in the face of suffering, and for what can still be despite all that cannot. The possibility that hospitalists could provide all patients access to palliative care is cause enough for hope. The knowledge that hospitalists will play a major role in making this possibility a reality and may become the predominant providers of palliative care can make that hope a reality.

Address for correspondence and reprint requests: Steven Z. Pantilat, MD, Associate Professor of Clinical Medicine, Alan M. Kates and John M. Burnard Endowed Chair in Palliative Care, Director, Palliative Care Service and Palliative Care Leadership Center, Department of Medicine, University of California, San Francisco, 521 Parnassus Ave., Suite C-126, UCSF, Box 0903, San Francisco, CA 94143-0903; Fax: (415) 476-5020; E-mail: stevep@medicine.ucsf.edu

Received 5 December 2005; accepted 5 December 2005.

REFERENCES

1. Meier DE. Palliative care in hospitals. *J Hosp Med.* 2006;1: 21–28.
2. Pantilat SZ, Billings JA. Prevalence and structure of palliative care services in California hospitals. *Arch Intern Med.* 2003; 163:1084–1088.
3. Pantilat SZ, Rabow MW, Citko J, von Gunten CF, Auerbach AD, Ferris FD. Evaluation of the California Hospital Initiative in Palliative Services (CHIPS). *Arch Intern Med.* In press.
4. Muir JC, Arnold RM. Palliative care and the hospitalist: an opportunity for cross-fertilization. *Am J Med.* 2001;111:10S–14S.
5. Field MJ, Cassell CK, Eds. Approaching death: improving care at the end of life. Washington, DC: National Academy Press, 1997.
6. Wachter RM, Goldman L. The hospitalist movement 5 years later. *JAMA.* 2002;287:487–494.
7. Plauth WH 3rd, Pantilat SZ, Wachter RM, Fenton CL. Hospitalists' perceptions of their residency training needs: results of a national survey. *Am J Med.* 2001;111:247–254.
8. von Gunten CF. Secondary and tertiary palliative care in US hospitals. *JAMA.* 2002;287:875–881.