

Dog with a Bone

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When a dog gets a bone, he doesn't go out and make a down payment on a bigger bone. He buries the one he's got.

—Will Rogers

EARLY CAREER

MOST PEOPLE ARE SURPRISED to learn I started out to be a laboratory chemist. In 1977, when I was working on my master's degree in clinical chemistry at the University of Toronto in the hospital laboratory after my undergraduate training in Cooperative Applied Chemistry at the University of Waterloo in Ontario, Canada, I initiated making hospital rounds with the clinicians. Both I and the technicians in the laboratory loved knowing how our work "fit in" with the actual care of patients. In addition to loving the clinical correlations, I made the observation that, if I ever wanted to be the head of the laboratory, I needed a medical degree. My mother was furious that I went back to school when I was so close to a perfectly respectable career.

After medical school at McMaster University in Ontario, Canada, I trained in internal medicine at the Wellesley and Western Hospitals (University of Toronto). Then, I trained in radiation oncology at the Princess Margaret Hospital and Toronto-Bayview Regional Cancer Center (University of Toronto). It did

not take me long to realize I was more interested in managing pain and other symptoms than I was debating whether the cure rate from whole beam radiation was 89.4% or 91.3% for stage IA Hodgkin's disease. Since there were no palliative medicine fellowships in Canada in 1987, I negotiated my own 3-year fellowship in pain and symptom management with Dr. Ian Kerr, a medical oncologist at the Toronto-Bayview Regional Cancer Center. It took me 20 years after high school before I finally found my niche and got a real job. My mother was profoundly relieved!

There were two "bad deaths" during that time that influenced me. My father had advanced Parkinson's disease and died 1 week after moving to a nursing home. He had fallen out of bed and died of acute pneumonia 12 hours after returning from the hospital where he'd been x-rayed to rule out a hip fracture. I was furious at the care he received and his sudden, unexpected death. However, my mother, having just lost her husband of 35 years said, "Frank, your father is dead. Don't waste your time being angry at the nursing home. Put your energy into activities that will make the world a better place for the living." When my very

close friend, Christopher Covert, died of complications from acquired immune deficiency syndrome (AIDS) in the hospital where I worked, and where even I could not prevent him from being overhydrated and undertreated symptomatically, I remembered my mother's advice, and redoubled my efforts. No one should have to die the way they did at that time period.

THE TIPPING POINT

In 1990, two dear nursing friends, Marilyn Lundy and Shirley Herron, pioneers in palliative home care and inpatient palliative care in Toronto told me I needed to meet Dr. Larry Librach, a family physician who had initiated an inpatient palliative care program at Mt. Sinai Hospital (University of Toronto) and needed help to start a home-based consult service. They orchestrated a lunch meeting that changed my life. Larry and I worked together for almost a decade and developed inpatient and home-based palliative consultation services that are now government funded and serve as models in the Province of Ontario.

In the course of that work, I noticed that there were no standards for palliative care in Canada. Most people think Canadians have a single health system; they are wrong. Each province has its own system with its own rules. While there is the Canada Health Act with which each province must comply, there is great variability in the healthcare services in each province. At the time, hospice or palliative care was not mentioned in the Canada Health Act, and not paid for by any of the Provincial Ministries of Health. The major problem was the wide diversity of people who thought they were doing palliative care and thought everyone should do it their way. This variability was far greater than in the United States because there was no stimulus for conformity like the Hospice Medicare Benefit. Most hospice programs were staffed by volunteers; I served on the Board of Directors of Hospice Markham-Stouffville (just northeast of Toronto). Most palliative care programs were hospital-based, doctor/nurse-driven, and idiosyncratic to the personalities at hand. The gulf between them was wide.

I distinctly remember a cocktail party where a government official for the Ontario Ministry of Health made the remark that, "as long as you can't agree among yourselves, don't come to the government—until you have one voice with one message and one thing everyone wants, we'll tell you to go back and play in your sandbox and you'll get nothing." I took that as a challenge.

CONSOLIDATION

From 1989, I worked with the standards committee of the Metropolitan Toronto Palliative Care Council. Then, from 1994, I led the standards committee of the Canadian Hospice Palliative Care Association to develop a national consensus on draft norms of practice that could apply across all of the 14 different health care systems in Canada. Since there was no external reason (like money) to get them to agree, it took 13 years of painstaking group process to get all participants to agree to a common language and a common set of principles that applied to all "hospice palliative care"—whether it was done in volunteer hospice programs, or in government-funded homecare programs, acute care hospitals or long-term care facilities. Finally, in 2003, our "one voice" resulted in national legislation that incorporated palliative care into the Canada Health Act. The new directives (including money) to make palliative homecare and the medications needed to support it available in every province in Canada were based on the "Model to Guide Hospice Palliative Care" (The Model) we had published in 2002 as the nationally accepted norms of practice.^{1,2} Subsequently, The Model has had a significant "ripple effect"—it has been used to develop nursing, pediatric, residential, and volunteer hospice palliative care standards; to develop medical and nursing curricula; to influence acute and long-term care facility accreditation standards; and to guide national research strategies.

MOVE TO THE UNITED STATES

In 1989, I had the good fortune to be asked by Linda Emanuel, M.D., Ph.D., to play a leading role in the development of the Education for Physicians on End-of-life Care (EPEC) Project. With Larry Librach's blessing, I figuratively (if not literally) moved to Chicago to help her, Charles von Gunten, M.D., Ph.D., and the team bring this project across the finish line. So much of what I learned in Canada over the previous years went into the document—The Model infuses every page of both the EPEC and the EPEC-Oncology Curricula we launched in 1999 and 2005, respectively.^{3,4}

In 1999, Laurel Herbst, M.D. and Jan Cetti, CEO of San Diego Hospice & Palliative Care (SDHPC) invited me to join Charles von Gunten and move to San Diego to continue my work on standards, the teaching and advocacy that stemmed from EPEC, and the related projects at the Center to Advance Palliative Care. A Faculty Scholar award from the Project on Death in

America at the Open Society Institute (funded by George Soros) helped to make it possible.

It was difficult for me to leave Canada both for the obvious reasons of moving to a new country and culture, but more specifically because physicians who “go south of the border” to work are generally shunned as traitors to the socialist ideals of the Canadian Health Care System. Happily, I am still greeted warmly in Canada. I am still invited to teach and, more importantly, to help with the continuing reach of the Canadian Standards Project as it rolls out in the Canadian Healthcare System. Since I moved to San Diego, in addition to my work with the EPEC Project and standards of practice,⁵⁻⁷ SDHPC has proved me with amazing opportunities to build on what I learned in Canada through work with the Center to Advance Palliative Care to develop strategies to implement palliative care in acute care hospitals; with The California Hospital Inpatient Palliative Service (CHIPS) Project to test this approach in California;⁹ with SDHPC to change how 500 clinical staff approach pain management;¹⁰ to integrate palliative care into wound care (and vice versa),^{11,12} and now with the Archstone Foundation to use bedside mentorship to change the experience of patients and families on hospice care in long-term care facilities.¹³

GOING GLOBAL

I have mostly recently taken my passion for teaching and standards to developing countries. I have used the skills I learned in Canada and honed in the United States to bring political and regulatory leaders together with doctors and nurses to implement palliative care in developing countries that see the need to implement the WHO Public Health Strategy for their people.¹⁴ Jan Stjernsward, M.D. and Kathy Foley, M.D. have been principal mentors and collaborators in this new stage in my life. I laugh a bit at my travel itinerary—it looks more like something from Phineas Fogg and *Around the World in 80 Days* than a usual physician calendar—here one day, there the next day. Over the last 2 years I have been part of educational programs in Canada, Egypt, Georgia, Jordan, Mexico, Mongolia, the Philippines, Spain, Sweden, and the Ukraine.^{15,16} Concurrently, I developed a unique International Palliative Medicine Fellowship based on U.S. Fellowship training standards and have trained fellows from Jordan, Georgia, Mongolia, and Slovenia.

Just as in the United States, there’s nothing so galvanizing as a patient in abject misery transformed to comfort within hours after attentive listening and ap-

propriate dosing of morphine. It is fun and deeply rewarding to watch doctors, nurses, and others in developing countries feel like miracle workers, and then want to teach all of their colleagues the same skills.

It has been thrilling to include U.S. fellows training in hospice and palliative medicine from SDHPC as faculty—you never learn something so much as when you have to teach it in the classroom, then mentor and proctor it at the bedside of real patients in a foreign country through a translator. Inevitably, the many lessons learned change their practice in the United States.

LESSONS LEARNED

I like to think of myself as an easy-going, people-oriented person. However, I am forced to admit that when I am focused on a project, like the Canadian Standards Project, or implementing palliative care in a developing country, I am more like a dog with a bone that will not put it down. Dogs are persistent in their passion for their bones and they do not give a bone up easily. As I reflect, this is an important characteristic of my success, and something worth passing on: be “passionate and persistent.” There are so many opportunities to become discouraged and to quit. When my collaborators and I were engaged in the long slog through snowy Canadian winters to small crowds gathered in local halls to debate whether hospice was different from palliative care, there were many times when I wondered if we would make a difference. The competing points of view that were based on emotion and local culture seemed, at times, irreconcilable. Yet, the big objective, of making sure everyone gets the relief of suffering they deserve, was sustaining.

HOPES FOR THE FUTURE

As I watch the integration of palliative care into the day-to-day practice of health care systems and professionals across North America, and around the world, I see that their approach to patients, families, and life is transformed for the better for everyone involved. Today, I believe that we will see the day when palliative care is an integral part of health care practice; where “everyone communicates and negotiates goals of care effectively” based on patient preferences and realistic therapeutic outcomes; where patients living with advanced illnesses have the capacity to live life to the fullest; and where the impact of illness and suffering on families and societies is markedly re-

duced. I believe that the integration of palliative care into health care is not only a strategy to express human kindness, it is also a strategy to facilitate peace worldwide.

So, if there is any wisdom to be gained from my story, it is: mix passion and persistence. Dream big, hold on tight, be patient, focus, and do not give up. After all:

The standards of practice we create and the people we train will look after us when it's our turn to receive care . . . Are you ready?"¹⁷

REFERENCES

- Ferris FD, Balfour HM, Bowen K, Farley J, Hardwick M, Lamontagne C, Lundy M, Syme A, West P: A model to guide hospice palliative care. Ottawa, ON: Canadian Hospice Palliative Care Association, March 2002. (www.chpca.net/marketplace/national_norms/national_norms_of_practice.htm) (Last accessed March 10, 2008).
- Ferris F, Balfour H, Bowen K, Farley J, Hardwick M, Lamontagne C, Lundy M, Syme A, West P: A model to guide patient and family care. Based on nationally accepted principles and norms of practice. *J Pain Symptom Manage* 2002;24:106–23.
- Emanuel LL, von Gunten CF, Ferris FD: The education for physicians on end-of-life care (EPEC) curriculum. American Medical Association, Chicago, IL, 1999. (www.epec.net) (Last accessed March 10, 2008).
- Emanuel LL, Ferris FD, von Gunten CF, Von Roenn J: EPEC-O: Education in Palliative and End-of-life Care for Oncology. 2005. (www.epec.net) or (www.cancer.gov/aboutnci/epeco) (Last accessed March 10, 2008).
- Robinson K, Sutton S, von Gunten CF, Ferris FD, Molodyko N, Martinez J, Emanuel LL: Assessment of the education for physicians on end-of-life Care (EPEC) curriculum. *J Palliat Med* 2004;7:637–645. [see also (www.epec.net)] (Last accessed March 10, 2008).
- Ferris FD, Gomez-Batiste X, Furst CJ, Connor S: Implementing Quality Palliative Care. *J Pain Symptom Manage* 2007;33:533–541.
- Ferris FD: Standards of care. In: Bruera E, Higginson IJ, Ripamonti C, von Gunten CF (eds): *Textbook of Palliative Medicine*. London, UK: Hodder Arnold, 2006, pp. 217–230.
- von Gunten CF, Ferris FD, Portenoy R, Glajchen M: CAPCManual: Everything you wanted to know about establishing a palliative care program but were afraid to ask. New York, NY: Center to Advance Palliative Care, November 2001. (www.cpsonline.info/capcmanual/index.html) (Last accessed March 10, 2008).
- Pantilat SZ, Rabow MW, Citko J, von Gunten CF, Auerbach AD, Ferris FD: Evaluating the California Hospital Initiative in Palliative Services. *Arch Intern Med* 2006; 166:227–230
- Buckholz G, Pirrello R, O'Mary S, Bull M, Ferris FD: The Development and Implementation of a Pain Management Curriculum for all Staff of a Large Hospice and Palliative Care Organization (Workshop). Academy of Hospice and Palliative Medicine/Hospice and Palliative Nurses Association Annual Assembly. Nashville, Tennessee: February 8–11, 2006.
- Ferris FD, Al Khateib AA, Fromantin I, Hoplamazian L, Hurd T, Krasner DL, Maida V, Price P, Rich-Vanderbij L: Palliative wound care: managing chronic wounds across life's continuum: a consensus statement from the International Palliative Wound Care Initiative. *J Palliat Med* 2007;10:37–39
- Ferris FD: Management of pressure ulcers and fungating wounds. In: Berger AM, Shuster JL, Von Roenn JH (eds): *Principles and Practice of Palliative Care and Supportive Oncology, 3rd edition*. Philadelphia, PA: Lippincott Williams & Wilkins, 2007. pp. 239–252.
- Archstone Foundation, Long Beach, California, see <http://www.archstone.org>
- Stjernsward J, Foley KM, Ferris FD: The public health strategy for palliative care. *J Pain Symptom Manage* 2007; 33:486–493.
- Stjernsward J, Ferris FD, Khleif SN, Jamous W, Treish IM, Milhem M, Bushnaq M, Al Khateib A, Al Shtiat MN, Wheeler MS, Alwan A: Jordan Palliative Care Initiative: A WHO Demonstration Project. *J Pain Symptom Manage* 2007;33:628–633.
- Davaasuren O, Stjernsward J, Callaway M, Tsetsegdary G, Hagan R, Govind S, Munkhdelger C, Ferris FD, Wheeler MS: Mongolia: Establishing a national palliative care program. *J Pain Symptom Manage* 2007;33:568–572.
- Ferris FD, Balfour HM, Bowen K, Farley J, Hardwick M, Lamontagne C, Lundy M, Syme A, West P: A model to guide hospice palliative care. Ottawa, ON: Canadian Hospice Palliative Care Association, March 2002, page 105 (back cover). (www.chpca.net/marketplace/national_norms/national_norms_of_practice.htm) (Last accessed March 10, 2008).

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