

On the Endangered Species List: Palliative Care Junior Faculty

VYJEYANTHI S. PERIYAKOIL, M.D.

THE PALLIATOR'S DIARIES

"Hey, shouldn't you be out there saving lives"? My friend Charlie (software engineer, Silicon Valley whiz-kid) set down his latte on my table at the coffee shop and sat down.

"Wrong field! I told you that she is in palliative care, remember" answered Lisa (an interventional cardiology fellow) in an exaggerated stage whisper sitting down next to me.

I grinned at my friends through the fog of the steaming coffee, unmindful of their comments.

"*Palltive? . . . Pallytive care*"? Charlie said. "Sounds more like a tongue twister than like a new specialty in medicine. What is it about?"

I instantly launched into my well-rehearsed zealous spiel on human suffering, quality of life, and holistic care for about 2 minutes without taking a breath when Charlie interrupted.

"Sounds to me like a fancy name for a 'Degree in Hand Holding' to me. Why are you doing this? Is it the money?"

"Doubt it," Lisa answered for me, but her bafflement coming thru clearly. "In fact it is a difficult specialty you know . . . pretty depressing . . . caring for seriously ill patients all the time. Many of her patients die very fast"

"That may be a side effect of VJ and not the field" grinned Charlie.

"Are you in it because it is a new field?" asked Lisa, now genuinely curious.

"No. Actually, I love to care for vulnerable and disenfranchised patients. It is wonderful and meaningful work. I can make a great positive impact on humanity by alleviating the suffering of patients with serious illnesses" I gave it another

shot, hoping to get them to see what was pretty obvious to me.

"Still sounds to me like a dead end—no pun intended" Charlie was chuckling when I thankfully got paged and quickly got up to answer it. It suddenly dawned on me that they were never going to "get it." I was now on a journey that many of my friends just could not comprehend and I began to feel intensely lonely right there in the middle of that crowded coffee shop.

A DEFINING TRAIT of doctors is an inordinate tolerance for delayed gratification. How else can one explain the 12 years of school, 4 years of college education, 4 years of medical school followed by residency and then specialization adding up to a grand total of a couple of decades in training? Meanwhile the medical school loans are mounting, our biologic clocks are ticking and frankly the primetime of our lives is slipping away as we are losing sleep (and hair in some cases) in our eternal struggle to mitigate human suffering. All this, while concurrently struggling to keep abreast of the ever-expanding medical literature (surely no mortal can) and the constant influx of new drugs and gadgets while working in socially complex health systems which are increasingly regulated, fiscally incentivised, and fraught with local politics.

While it is true that medicine is a lucrative profession, the tradeoffs are not trivial. According to the US Bureau of Labor Statistics,¹ more than one third of full-time physicians worked 60 hours or more per week in 2006. In addition, it is well documented that medicine is a very stressful profession with rates of alcoholism, drug misuse, and suicide that are several times higher than in comparable professions.² Indeed, people can and do earn much more money, and with a

Stanford University School of Medicine, Stanford, California.
VA Palo Alto Health Care System, Palo Alto, California.

considerably smaller personal investment, in careers other than medicine.³ Consequentially the numbers of applicants to medical school plummeted from 46,965 in 1996 to 33,625 in 2002.⁴ Of this, only a very small percentage will choose to specialize in palliative care and care for the 2.4 million Americans who will die every year.

PALLIATIVE CARE JUNIOR FACULTY IS VULNERABLE

The fate of dying Americans and the future of hospice and palliative medicine (HPM) is in the hands of current trainees and junior faculty. The next generation of HPM leaders face some unique challenges:

1. **Lack of critical mass:** There are two monetarily successful paths for most medical subspecialties.
 - The “*High-Tech*” pathway where a specialty has specialized skills/gadgets that are aimed at solving specific problems like cardiologists doing catheterizations.
 - The “*High-Volume*” pathway where the specialist is able to provide care to a large number of patients in a relatively short amount of time; the field of dermatology is an example.
 - Palliative care has forged a new “*High-Talk*” pathway with a major focus on communication skills and patient quality of life. This then makes HPM a low-tech (no specialized scopes or gadgets) and a relatively low-volume sub-specialty and thus not a high income subspecialty. A natural consequence of this is that fewer trainees will choose to specialize in HPM as it has been well documented⁵ that the specialty choice of medical students is influenced by their debt levels and the projected earnings. With the escalating costs of medical education, it is likely that our field may lack critical mass and therefore the lobbying force of other larger subspecialties.
2. **The counterculture of HPM:** The field of HPM evolved as an activist response against the traditional culture of biomedicine. However, many of the HPM pioneers originally came from traditional subspecialties like oncology, geriatrics, and general internal medicine and were/are well immersed in mainstream medicine. Often, the bulk of their early work was in their primary specialty. Their role in palliative care was a smaller component of their early career and it evolved gradually over time of-

ten shaped by the core needs of their home institutions. Thus they had/have the advantage of being nested within traditional biomedicine even while agitating for change and thereby creating the new subspecialty. In contrast, junior faculty today may enter the practice of HPM directly after fellowship training, without embracing (and in turn being embraced by) mainstream medicine. Therefore, junior faculty runs the risk of being distanced from the inner core of the medical system that will weaken their local political clout.

3. **Research challenges:** Research challenges inherent to HPM are well documented elsewhere⁶ and beyond the scope of this essay. Suffice it to say HPM junior faculty has to overcome not only complex design and execution challenges but also identify and secure funding from the highly competitive and ever diminishing extramural and intramural funding sources while concurrently attempting to keep up with the demands of working in a very stressful and challenging subspecialty of medicine.
4. **Pro bono teaching:** There is a critical need for HPM education at multiple levels ranging from medical students, clinicians of all disciplines, and faculty. HPM junior faculty is expected to participate in curricular development and delivery as well as in numerous other ongoing educational efforts. These educational efforts are typically neither subsidized nor “billable activity” and can, over time, greatly add to their work volume and stress.

FORTIFYING JUNIOR FACULTY

The need for concerted national efforts—much similar to the pioneering work Dr. Block describes in her essay⁷—to support junior HPM faculty in their professional development cannot be overstated. Such efforts should focus on:

1. Identifying and supporting strategies for HPM faculty to remain nested within mainstream medical system while
2. Concurrently strengthening the countercultural activist heart of HPM and agitating for change
3. Teaching junior faculty to market themselves and the field by strategic outreach to powerful socio-political networks that will increase the visibility and thereby the staying power of the field.
4. Teaching junior faculty leadership and administrative skills that will help them further build and sustain the field of Palliative Care.

While these tasks may sound daunting, surely we can take hope from the fact that the leaders and pioneers in the field of palliative care are incredibly generous and willing to mentor junior faculty and trainees. With generous mentors like Dr. Block and other pioneers, we can surmount barriers and emerge as strong and viable medical subspecialty even while preserving the heart and soul of palliative care.

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Address reprint requests to:
Vyjeyanthi S. Periyakoil, M.D.
3801 Miranda Avenue
100-4A
Palo Alto, CA 94304

E-mail: periyakoil@stanford.edu