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The number of training programs “will increase dramatically with the advent of ABMS subspecialty approval,” Dr. Diane E. Meier said.

## Palliative Medicine Gaining Ground

BY MITCHEL L. ZOLER  
Philadelphia Bureau

The pending designation of hospice and palliative medicine as a subspecialty by the American Board of Medical Specialties is expected to hasten the spread of palliative medicine into routine medical care, and may boost the number of physicians who train and seek certification in this field.

The American Board of Internal Medicine (ABIM) submitted an application in September 2005 to the American Board of Medical Specialties (ABMS) to make hospice and palliative medicine a subspecialty of internal medicine. The application was cosponsored by five other boards, with cosponsorship from an additional board expected soon. A decision by the ABMS is expected in September 2006, with the first certification examination probably to be administered in 2008.

“Almost every physician needs to know the basics of palliative medicine. The more legitimacy and visibility [palliative medicine] gets, the more likely that will happen. Patients don’t need to be terminally ill to benefit from palliative care,” said Dr. Christine K. Cassel, president of the ABIM in Philadelphia.

The availability of board-certified

specialists in the field provides the experts who in turn write the textbooks, teach, and lead the major programs, Dr. Cassel added.

The vast majority of currently certified physicians were trained in internal medicine, a pattern that’s expected to continue.

“Care of patients with advanced and complex illness and multiple comorbidities has always been the province of internists,” said Dr. Diane E. Meier, director of the Palliative Care Institute at Mount Sinai Medical Center in New York.

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Simple bed-elevation gauge may reduce the risk of aspiration pneumonia.

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Increased rate of diabetes points to possible link.

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## Panel Urges Health Care Workers to Get New Tdap Shot

Goal is to prevent the spread of pertussis.

BY MIRIAM E. TUCKER  
Senior Writer

ATLANTA — Health care workers in hospitals or ambulatory care settings and those who have direct patient contact should receive the adolescent/adult formulation of the tetanus-diphtheria-acellular pertussis vaccine, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention voted at its winter meeting.

The new recommendation is aimed at protecting health care workers as well as their patients. “Preventing pertussis among health care workers will decrease exposures and secondary cases in both pediatric and adult care

settings,” said Dr. Trudy Murphy of the CDC’s National Immunization Program.

Like the tetanus-diphtheria (Td) vaccine that it replaces, the tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine, adsorbed (Tdap) is routinely recommended at intervals of 10 years for all adults. But an interval as short as 2 years is now advised for the Tdap dose among health care workers in ambulatory and acute care settings, including physicians, nurses, aides, respiratory therapists, medical and other students, social workers, and clerical workers, among others.

Priority should be given to vaccination.  
See **Tdap Shot** page 4

## ‘Active Surveillance’ Meets A Need in Early Prostate Ca

BY DIANA MAHONEY  
New England Bureau

SAN FRANCISCO — A management strategy described as “active surveillance with delayed intervention” for men with low-risk, early-stage prostate cancer can identify those patients whose cancer growth warrants aggressive intervention while minimizing the possibility of overtreating men with slow-growing cancer, Dr. Laurence H. Klotz reported at a symposium on prostate cancer sponsored by the American Society of Clinical Oncology.

A compromise between watchful waiting with palliative care and radical intervention, the proposed strategy calls for regular prostate-specific antigen (PSA) testing and periodic prostate biopsies for patients whose prostate cancer is deemed low risk based on the extent of cancer spread and the rate of PSA rise.

When the PSA and biopsy changes are suggestive of cancer growth that might move the patient into a less favorable risk category, “the patient is offered radical intervention—whether surgery, radiation therapy, or  
See **Active Surveillance** page 8

## REINVENTING YOUR PRACTICE

Are you ready for the era of information technology and performance measurement? Enter our contest on **Reinventing Your Practice** by telling us what you’ve done to make your practice more efficient.

We’ll award a video iPod to the top six contestants. See p. 63 for a partial list of practice redesign topics and instructions for submitting your entry.

Watch future issues of INTERNAL MEDICINE NEWS to read the winning entries, as well as other ideas we receive from **Reinventing Your Practice** contestants.



## New Subspecialty Moves Ahead

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"I believe that the majority of future palliative medicine specialists will come through internal medicine programs, with smaller numbers from family medicine, and quite likely pediatrics and surgery," Dr. Meier said.

"Internists are increasingly familiar with and open to learning about what palliative medicine has to offer to themselves and their patients," said Dr. Meier, who is among those already certified by the American Board of Hospice and Palliative Medicine, and who is planning to seek the new certification when it becomes available.

"It takes time for practicing physicians to adopt and incorporate new approaches to patient care. That process is well underway [for palliative medicine] as a result of the rapid growth in the number of palliative-care services in U.S. hospitals. Word of the value added for the sickest and

most complex patients spreads fast," added Dr. Meier, who also is a professor of geriatrics and internal medicine at Mount Sinai.

Recognition by the ABMS "is a very positive sign that hospice and palliative medicine is becoming an accepted part of routine medical care," observed Dr. Ronald S. Schonwetter, who is chief medical officer for LifePath Hospice and Palliative Care Inc. in Temple Terrace, Fla. He is also president-elect of the American Academy of Hospice and Palliative Medicine.

The emergence of hospice and palliative medicine has been on a fast track in recent years.

The American Board of Hospice and Palliative Medicine was created in 1995 as the first credentialing organization for this new branch of medicine. In 2004, this board as well as its sister organization, the

American Academy of Hospice and Palliative Medicine, made a formal request to the ABIM to sponsor a subspecialty certificate.

The ABIM responded to that request with unanimous support.

"That [process] generally takes a very long time. Some areas of medicine try and try to get the ABIM's approval," Dr. Cassel told this newspaper.

"What we look at is how many physicians actively practice, what training programs exist, and is there a science base and a substantial body of knowledge," she explained.

As of early 2005, about 1,900 physicians had been credentialed by the American Board of Hospice and Palliative Medi-

cine, and by early this year 60 fellowship training programs were in place in the United States.

The number of training programs "will increase dramatically with the advent of ABMS subspecialty approval," Dr. Meier predicted.

Joining the ABIM as cosponsors of the new subspecialty application are the American Board of Anesthesiology, the American Board of Family Medicine, the American Board of Physical Medicine and Rehabilitation, the American Board of Psychiatry and Neurology, and the American Board of Surgery.

Possible cosponsorship by the American Board of Pediatrics was pending at press time. ■

### TALK BACK

**How will the development of the subspecialty of hospice and palliative medicine affect you and your practice?**

Share your thoughts!  
Send e-mail to [imnews@elsevier.com](mailto:imnews@elsevier.com); write to  
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## Palliative Care Programs Now Operating at 1 in 4 Hospitals

BY DOUG BRUNK  
San Diego Bureau

The number of palliative care programs in U.S. hospitals grew from 632 in 2000 to 1,027 in 2003, an increase of 63%, according to results from a large study.

The study "demonstrates the increasing recognition by hospitals in the United States and those providing primary care for patients with advanced illness of the need for palliative care services," said Dr. R. Sean Morrison, the study's primary author.

"This is becoming part of what should be routine medical care. We have seen growth from a fraction of hospitals having hospital-based palliative care programs to where now one in four hospitals has a program," said Dr. Morrison, vice chair of research in the department of geriatrics at Mount Sinai Medical Center, New York.

He and his associates obtained data from the 2001-2004 American Hospital Association annual surveys, which covered calendar years 2000-2003. The AHA's annual survey defines a palliative care program as "an organized program providing specialized medical care, drugs, or therapies for the management of acute or chronic pain and/or the control of symptoms administered by specially trained physicians and other clinicians; and supportive care services, such as counseling on advanced directives, spiritual care, and social services, to patients with advanced disease and their families."

The researchers identified all programs that self-reported the presence of a hospital-owned palliative care program and acute medical and surgical beds, and then used multivariate logistic regression to pinpoint factors that were associated with

the presence of an adult palliative care program in the 2003 survey data (J. Palliat. Med. 2005;8:1127-34).

They found that hospitals in the Northeast, Pacific, and Mountain areas of the country were more likely than those in other geographic regions to have programs. The greater the number of hospital beds and acute care beds, the more likely it was that a facility had a palliative care program.

Similarly, being a Veterans Affairs hospital or a not-for-profit hospital increased the likelihood of having a palliative care program, the analysis showed.

Among the factors that were associated with having a palliative care program were being a member of the American Association of Medical Colleges Council of Teaching Hospitals and being a cancer hospital approved by the American College of Surgeons.

**'The expense of the program is far outweighed by the cost savings to our hospital for having it.'**

DR. MORRISON

"The fact that the American College of Surgeons would want to incorporate access to palliative care as one of their benchmarks of good care

in a cancer setting is a sign that palliative care has been very successful in legitimizing its place in the continuum of medical practice," observed Dr. Geoffrey P. Dunn, an Erie, Pa.-based surgeon who cochairs the ACS's Surgical Palliative Care Task Force.

"People are becoming increasingly aware that palliative care is an extension of the already well-known and very successful hospice programs in this country. As this study shows, there are more occasions where they will have the opportunity for those services," Dr. Dunn said.

"I think that's going to increasingly generate that expectation in care, whether it's at a cancer center or elsewhere," he added.

For-profit hospitals, however, are sig-



The palliative care team at a 300-bed hospital is likely to include a physician, a nurse, a social worker, and consultation with other core services.

nificantly less likely to have programs, according to the study. Dr. Morrison said that part of the reason may be the fact that palliative care programs started in academic medical centers and branched out to teaching hospitals.

"The majority of teaching hospitals in the United States are still not-for-profit," he said. "I don't think there is a lot of communication [about palliative care programs] between the not-for-profit sector and the for-profit sector, but it's something we'd like to address."

Dr. Morrison's study showed that there were 1,892 certified palliative medicine physicians as of July 2005 and 5,500 certified palliative nurses as of March 2005. It also showed that the number of postgraduate palliative medicine fellowships had increased from 17 in 2000 to 53 in 2005.

Dr. Morrison said that the cost of a hospital-based palliative care program is directly related to the size of the hospital. At Mount Sinai Medical Center, which is a 1,000-bed teaching hospital, the palliative

care program consists of two full-time physicians, four full-time nurse-practitioners, two full-time social workers, and consultation with chaplaincy and physical therapy.

"The expense of the program is far outweighed by the cost savings to our hospital for having it," said Dr. Morrison, whose study was funded by the Robert Wood Johnson Foundation.

"For a 300-bed hospital, the team is probably going to be a physician, a nurse, a social worker, and consultation with other core services. For a 50-bed rural hospital, it may be that the primary person is a nurse-practitioner with a part-time physician as backup in consultation with other services in the hospital," Dr. Morrison noted.

To access a financial calculator that can be used to estimate the cost of a palliative care program and the cost savings to a hospital, visit the Center to Advance Palliative Care's Web site at [www.capc.org](http://www.capc.org). Look for the "CAPC Impact Calculator" icon. ■

