Residents' Review

Can Anesthesiologists Bridge the Gap Between Primary and Specialty Palliative Care?

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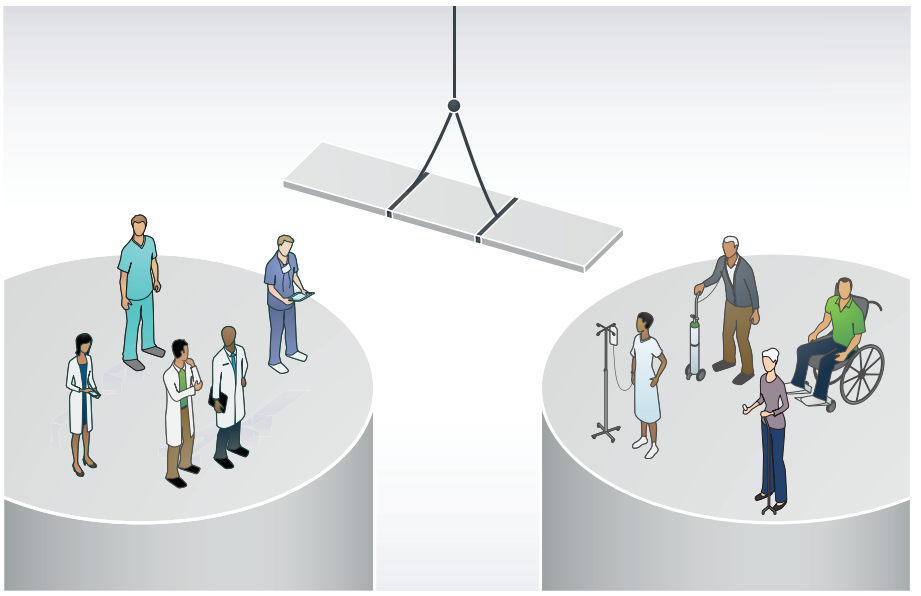
Anesthesiologists can and should play a larger role within the expanding specialty of palliative care. Their expertise in the use of analgesics, pain interventions, and perioperative medicine makes them uniquely suited to contribute to a multidisciplinary palliative care team that may help bridge the gap between primary and specialty palliative care. A wide breadth of training and focus on procedural skills make residency an ideal starting place for increasing the role that anesthesiologists can play within palliative medicine.

Physician anesthesiologists are the established experts in perioperative medicine, and they have also increasingly been asked to play a role in the expanding specialty of palliative care. This is particularly so as the demand for services continues to exceed the supply of formally trained palliative care specialists. Due to the nature of their training and unique skill set, anesthesiologists may be the ideal physicians to provide essential services to a subset of patients that, by all accounts, will continue to grow.

There are myriad ways by which anesthesiologists may be involved in palliative medicine, both in primary palliative care, which applies to the vast majority of diplomates, or in specialty palliative care, for those who wish to pursue further fellowship training in hospice and palliative medicine (HPM) (*ASA Monitor* 2021;85:41-2). Anesthesiologists are unique in that they may play a particularly nuanced role within a multidisciplinary palliative care team – as experts in providing high-quality perioperative anesthesia and as clinicians with broad experience treating acute and chronic pain. Anesthesiologists have developed unparalleled expertise in multimodal pain management, in addition to proficiencies in a range of procedural interventions that can have an especially meaningful impact upon a patient's quality of life. In contrast, physicians from other specialties may not be as familiar with the use of high doses of medication or the procedural tools for symptom management in palliative care. When anesthesiologists are involved in a multidisciplinary palliative care team, they have the opportunity to provide this expertise for the care of individual patients, as well as to influence



systems-based processes at the practice or hospital level.

One avenue for the expansion of anesthesiologists into palliative medicine is through a practice that aligns with the Perioperative Surgical Home (PSH) model, a physician-led and patient-centered multidisciplinary strategy of coordinated care that improves the perioperative patient experience (*ASA Monitor* 2015;79:28-30). An anesthesiologist has the potential to provide primary palliative care as part of the PSH across each of the phases of perioperative medicine. This could range from a preoperative goals-of-care discussion to an intraoperative consult with a palliative care specialist, followed by the postoperative titration of high-dose opiates with other pain adjuncts to ensure patient comfort and functionality during recovery. The integration of palliative medicine principles across the perioperative period stands to provide significant benefit for patient outcomes and satisfaction, and it may be worth exploring as a potential option for consolidating hospital costs. An increased focus on palliation may also be a means of further differentiating anesthesiologists from other members of the anesthesia care team.

A further benefit of increasing anesthesiologists' involvement in palliative care through avenues such as the PSH is that it may be a plausible approach to start bridging the gap between primary and specialist palliative care. A combination of generalist and specialist components has been posited as a means to a more sustainable model of expanding the scope of palliative care for patients (*N Engl J Med* 2013;368:1173-5). An anesthesiologist who has had more comprehensive training in symptomatic pain management, code status, and surgical care is poised to shift the workload off some of the fellowship-trained palliative care specialists within their hospital system. One way to accomplish this may be by the inclusion of hospice and palliative medicine curricula within preexisting anesthesia residency programs. This addition might allow new generations of anesthesiologists to function at a level between primary and specialty palliative care, providing expertise that further expands available palliative medicine capabilities. To accomplish this goal, additional training during residency may prove beneficial, be it through dedicated rotations, formalized education from experts in the field, or an increased exposure to the principles of palliative care. Where anesthesia training is strong in areas like opioid management and procedural pain treatment, current residency education does not include requirements in navigating complex goals-of-care discussions, mental health, or the nuanced psychosocial aspects of coping with a terminal illness or cancer diagnosis.

There appear to be no formal palliative care curricula that are specific to anesthesiology departments, though residents may have the opportunity to pursue elective rotations through their home institutions. Some have advocated for this to be a universally available opportunity, and it may be a promising option to explore as palliative medicine continues to expand; but this may not be feasible in rural settings or in lower-resource environments (*ASA Monitor* 2020;84:29). Exposure through didactic sessions may be a more immediately tangible solution for programs to consider, whether by in-house specialist lectures or, for instance, the clinician education available from the Stanford Palliative Care Center of Excellence or the American Academy of Hospice and Palliative Medicine.

As residency programs gain more familiarity with the tenets of palliative care, their natural alignment with the skills of an anesthesiologist may serve as a foundation from which to build the case for more robust and formalized training within anesthesia residency programs. Until then, program-sponsored introductions to palliative medicine may prompt residents to seek additional opportunities for further exposure, to pursue quality improvement projects within their own hospital systems, or to undertake subspecialty training through a fellowship in hospice and palliative medicine. As the demand for palliative care continues to rise, an increased focus on palliative care education within anesthesia residencies may be the perfect way to allow our specialty to expand the reach of an area of medicine that is of great benefit to our patients. ■

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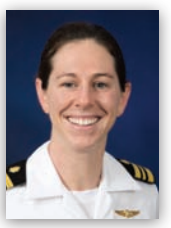

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