



THE HASTINGS CENTER
CUNNIFF-DIXON PHYSICIAN AWARDS



CUNNIFF
DIXON
FOUNDATION



*The mission of the
Cunniff-Dixon Foundation is to
enrich the physician-patient relationship
near the end of life. Our goal is to educate
individual physicians and inspire them to provide
the kind of care near the end of life that we all wish for
ourselves and our loved ones.*

*As part of the Foundation's efforts to achieve this goal,
we are committed to the annual presentation of
The Hastings Center Cunniff-Dixon Physician
Awards, which will go to physicians in recogni-
tion of clinical contributions and commit-
ment to the cause of end-of-life
medical care.*

There are five prizes totaling \$95,000.

Three of the awards will be in the amount of \$15,000 and will go to early-career physicians (less than 7 years in practice) who have demonstrated a serious commitment to and have already made a contribution, through practical research or clinical work, to the field of end-of-life medicine. The purpose of these awards will be primarily to recognize the recipients' commitment and to give them visible acknowledgment of their work. A second goal will be to reward them with a modest financial stipend at a time in their medical careers when daily life can be a financial struggle. And finally, we hope to make a statement to their peers that the world at large is aware of this important work, and thereby, perhaps encourage other young practitioners to focus on end-of-life care.

Two other prizes will be in the amount of \$25,000 each. The first will go to a mid career physician (8 to 20 years in practice), and the second to a senior physician (20 years plus in practice). These prizes will be awarded to physicians who have demonstrated – through leadership and practice – a serious and valuable commitment to end-of-life care. Palliative care entities and physicians frequently have a difficult time obtaining the funding required to achieve their objectives. Physicians who are passionate about giving terminal patients the time and attentiveness they deserve are typically not financially well rewarded for their efforts. This award is an attempt to recognize that financial struggle and to offset it in some modest way. In addition, it is about recognition in the physicians' communities for the important work they are doing.

These prizes are awarded by the Cunniff-Dixon Foundation in partnership with The Hastings Center, a bioethics research institute dedicated to exploring issues in medicine, public health, and science as they affect individuals, society, and the public interest. The prize recipients are selected by a committee convened by The Hastings Center.

PROGRAM DESCRIPTION

Care for patients at the end of life has long troubled American medicine, not only in its failure to provide good palliative care, but also in the relationship of doctors and patients. Many efforts to remedy this situation have emerged: a growing and strengthening palliative care movement, efforts to better understand the situation of patients at the end of life, a sharper focus on the values and behavior of physicians in their care of the dying, and a more general effort to gain medical recognition that end-of-life care is just as important as care during all other phases of life. Great progress has been made, but there is still a distance to go. As the number and percentage of people who die from chronic and degenerative diseases increase, and the process of dying is often uncertain and tenuous, the physician skills and virtues necessary to provide good end-of-life care increase.

The aim of The Hastings Center Cunniff-Dixon Physician Awards is to foster those skills and virtues by providing financial prizes to those physicians, young and old, who have shown their care of patients to be exemplary, a model of good medicine for other physicians, and a great benefit in advancing the centrality of end-of-life care as a basic part of the doctor-patient relationship.



CRITERIA FOR THE AWARDS

The criteria for the awards have been established by The Hastings Center Selection Committee, which was convened specifically for this purpose.

The committee consists of:

Richard Payne, M.D., is Professor of Medicine and Divinity at Duke Divinity School, Duke University, and the Esther Colliflower Director of the Duke Institute on Care at the End of Life.

Thomas P. Duffy, M.D., is Professor of Medicine at Yale University School of Medicine and Director of The Program for Humanities in Medicine at Yale.

Kathleen M. Foley, M.D., is Professor of Neurology, Neuroscience, and Clinical Pharmacology at Weill Medical College of Cornell University. She is also an Attending Neurologist in the Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center in New York City.

Larry R. Churchill, Ph.D., is the Ann Geddes Stahlman Chair of Medical Ethics at Vanderbilt University. He also holds appointments in the Vanderbilt Divinity School and in the Department of Philosophy.

The criteria are five-fold:

- technical competence
- personal integrity
- doctor-patient dialogue
- active engagement of friends and family
- ability to function well as part of a care team.

There will of course be some overlap of the criteria.

Technical Competence

Competence is a baseline requirement. It encompasses both technical knowledge of the best means of palliative care, medically and pharmaceutically, as well as skill in determining how best to deploy them with individual patients. The 'art' of medicine, as well as the 'science' of medicine, comes into play.

Personal Integrity

By personal integrity is meant that combination of personality traits and virtues most conducive to good end-of-life care. Given the frequent medical uncertainty of such care and the individual differences among patients in response to their treatment, humility is a key virtue. That means knowing what one does not know, a willingness to shift modes of treatment when an earlier course proves inefficacious, and a sharing of uncertainty with colleagues.

Friendship with patients, though not always possible, is an advantage. Dying can be lonely. The patient is sometimes bereft of family and friends, and often only the physician is in a position to be a steadfast companion. Availability is hardly less important: being there when a patient needs care, which means an openness to inconvenience and schedule disruption. A willingness to make house calls to avoid unnecessary visits to hospitals or physician offices is an important mark of availability. Most fundamentally, patients need to know they will not be abandoned. At times families, in effect, abandon their loved ones, sometimes because they were not close in the first place, or because they cannot cope with the reality of a loved one's dying. But, come what may, the physician must be there until the very end.



NOMINATION PROCESS

Nominations will be accepted annually through September 30. Information regarding the nomination process will be available on the website of each organization. The Duke Institute on Care at the End of Life is playing a major role in the nomination and selection process, and information will also be available on the ICEOL website.

DOCTOR-PATIENT DIALOGUE

Physicians need to talk with patients, and patients need to talk with physicians. The notion of dialogue catches the need here better than the more common concept of communication. Dialogue is give and take, back and forth. Doctors need to understand their patients, how they think and feel, and what they value in their lives. Patients need to know what their physician makes of them, how seriously their situation is being taken, and what the course and nature of their treatment will be. Patients need to know where they stand with their doctor: is the patient just another technical case, or does the doctor patently understand that treatment of the dying has a unique status, quite unlike any other doctor-patient relationship.

As far as possible, the dying should be actively engaged in their care. Minimally, this means understanding the likely nature, course, and trajectory of their treatment. Their physician should let them know what to expect and what is being done to help them. Not all patients want this kind of knowledge or engagement, and a physician's first task should be to assess their patient, to gain a sense of what to say and not say – that is, what kind of a dialogue it is likely to be, and how to work to change it if initially not promising. A great benefit for many patients is for their physician to keep them active in their remaining life; be out and about if possible.

Active Engagement of Family and Friends

Most patients have family and friends, and how a patient fares will be affected by their relationship with them. They can be supportive, or fearful, or anxious, distant or close to the patient. The family needs its own assessment and dialogue initiated with them as well as the patient. They may or may not know what the patient had said earlier about care at the end of his life; or they may know and that can be helpful with a patient fading in and out of competence. While a physician may not be well placed to help resolve some problems or tensions between patients and families, it is useful to be aware of them.

Team Work

Few physicians work alone now and, with end-of-life care, cooperation among caregivers is crucial. There will be different people providing different kinds of care, and coordination among them is important, particularly with nurses and nursing assistants. Continuity of care is especially important, and the principal physician caring for the patient has a special responsibility to make certain the patient knows who is in charge and that the personal physician is there when needed. On occasion, as with home care, it will be the nurse who provides the care, usually guiding and advising the physician. The ability to work well with a team is an important ingredient of good care.