Dear Colleagues:

Over the past generation, palliative care has had a profound impact on our patients and our healthcare system. It has not only revolutionized the care of patients near the end of life, it has also helped transform our approach to symptom management, care across the continuum, communication, medical ethics – even what it means to be alive. Palliative care has also promoted interdisciplinary teams and patient- and family-centered decision-making.

Palliative care cuts across many fields, and our current organizational structure at UCSF Health (Parnassus, Mt. Zion, Mission Bay, and home-based care under the UCSF Health umbrella), which evolved organically, has not kept up with the growth and complexity of the program. Currently at UCSF Health sites, inpatient palliative care is delivered by faculty in the Division of Hospital Medicine, outpatient palliative care mostly by faculty in the Division of General Internal Medicine (with the cancer-focused Symptom Management Service taking the lead), and home-based palliative care by faculty in the Division of Geriatrics. There are additional faculty interested in palliative care in several of our subspecialty divisions. While there have been useful efforts to promote integration and coordination (including a UCSF Health Palliative Care Strategic Plan), the structure remains imperfect.

The lack of a clear structure comes at a cost – for patients as they transition across these boundaries; for UCSF Health as it considers developing or growing palliative care programs; for funders and donors who seek to support palliative care at UCSF; for existing faculty, who often find themselves straddling two or three divisions; and for prospective faculty, for whom applying for a palliative care job can be confusing, even off-putting.

After months of rich discussion with the relevant parties, I have decided to create a *new Division of Palliative Medicine (DPM) at UCSF Health*. This division will be charged with overseeing the clinical, educational, and research programs in adult palliative medicine at UCSF Health sites. It will *not* change the current structure at the VA, where palliative care is well integrated into the Division of Geriatrics, nor at ZSFG, where a growing palliative care program currently lives within the Division of Hospital Medicine.

This new Division of Palliative Medicine deserves a chief with national stature and superb leadership skills. For that reason and to promote an open process, we will launch a national search for a chief of the UCSF Health DPM. I am grateful to Catherine Lucey, Professor of Medicine and Vice Dean for Education, for agreeing to chair this search. We will aim to have the DPM begin operations in spring 2018 under its new leader. Until that time, the current structure will remain in place.

Over the next year, I will work with our palliative care leaders in the department to develop the business plan and make other important decisions to plan for the new division. While there are likely to be a few exceptions, it is fair to assume that faculty who are boarded solely in palliative medicine *and* whose primary focus is on palliative care at a UCSF Health site will become members of this new division, as will any palliative care research faculty whose support comes primarily from the new Division of Palliative Medicine. I expect that many faculty who transition to the DPM will have close ties to other divisions, including their current ones, and we'll do all we can to respect and nurture these bonds. Given the interdisciplinary nature of palliative care, we will also build the DPM to promote strong relationships with professionals in other disciplines that are essential to the provision of extraordinary palliative care, including social workers, nurses, nurse practitioners, chaplains, and case managers, as well as with interested faculty in other departments.

One benefit of my discussions has been to highlight the world-class research in palliative care being done today, across the department and university. To promote synergy between researchers in the new DPM and our superb palliative care researchers in divisions such as geriatrics, nephrology, and hospital medicine, I have asked Christine Ritchie, Professor in Clinical Translational Research and Aging in the Division of Geriatrics, to chair a task force that will recommend a structure to bring our palliative care researchers together and create maximum synergies, perhaps under a research center model. I am grateful to Christine for taking on this important role.

My sincere thanks to all of the individuals who spoke with and wrote to me to share their thoughts about this issue. Special thanks to the chiefs of the divisions most affected by this change: Louise Walter (geriatrics), Brad Sharpe (hospital medicine), and Mitch Feldman (general internal medicine), and to the members of the Palliative Care Strategic Leadership Group: Mike Rabow, Christine Ritchie, Rebecca Sudore, and Steve Pantilat. We are lucky to have extraordinary palliative care leaders in our department, and I truly appreciate their support.

There is nothing that we do that is more important than palliative care, and I am confident that this new structure will help us deliver it, teach it, and advance the science of it even better.

-- Bob

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