Journal of Palliative Care & Medicine
ISSN: 2165-7386
Rialon et al. J Palliative Care Med 2012, 2:2
DOI: 10.4172/2165-7386.1000e115
Editorial Open Access

Integration of Palliative Surgery into the Palliative Care Delivery Team

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Palliative surgery is not a new concept [1,2]. In recent years, however, there has been an increased appreciation for palliative care as an area of special need and expertise, but the breadth and integration of various specialty components remains variable [3]. This is compounded by the fragmentation of healthcare in the U.S. [4,5]. Implementation of palliative surgery, in particular, as an integrated component of palliative care remains a challenge.

Proper integration of surgery into a multidisciplinary palliative care team is essential on a number of levels. First, and most important, palliative surgery can contribute to the provision of effective, high quality symptom management and the alleviation of suffering in patients with chronic illness. Surgeons possess the technical expertise to perform palliative surgical procedures like venting gastrostomies, intrabronchial stents, and bypass of a malignant bowel obstruction. When surgeons are not involved in palliative care services, patients who may be optimal candidates for surgical palliation may not be referred for a surgical opinion, may not be referred in a timely fashion, or may be referred to a surgeon who is uncomfortable with or inexperienced in this area of expertise.

Second, patients who undergo palliative surgery may have special needs for care coordination and continuity. Such patients may have complex postoperative care needs that must be considered in the discharge planning process, such as drain and tube management, wound and enterostomal care, and other specialized nursing requirements. Importantly, if a palliative surgery was conducted to relieve symptoms but the postoperative management is improper or inadequate, the symptom management opportunity can be completely erased - or symptoms even worsened compared with the preoperative state. Inclusion of surgeons, and their surgical nursing colleagues, into the palliative care team provides a practical mechanism to ensure patients get the best postoperative management and maximal benefit from palliative interventions.

The cost-effectiveness of palliative surgical care is a third consideration. This topic is likely to receive increasing attention in the future due to the extraordinarily high cost of healthcare in the U.S. toward the end of life [6]. Proper patient selection is key to cost-effectiveness in order to ensure that patients who are likely to benefit from palliative surgery receive, or are considered for, appropriate surgical intervention - and those who are poor candidates do not. One source of added cost may be prolongation of hospital stay, either because of a delay in surgical intervention or inefficiencies in coordinating and executing appropriate discharge plans. Strong relationships between palliative care teams, especially inpatient palliative care teams, and surgeons can help ensure more appropriate patient selection, timely referral, and timely discharge.

Fourth, inclusion of surgeons in a palliative care team environment not only benefits palliative care clinicians and patients - it benefits surgeons too. Increased exposure of surgeons to the needs and sources of suffering experienced by people with advanced life-limiting illness will enhance surgeons' understanding, improve communication skills, and facilitate care coordination. Innovation of new palliative surgical techniques requires that surgeons hear and understand the breadth of biopsychosocial problems that patients face. Surgeons will likely need additional education in palliative care to cover end-of-life issues not discussed in previous training [7,8]. And exposure to palliative care teams means that surgeons who may have been reluctant to seek palliative care consultation perioperatively or were not be aware that such assistance is available or appropriate would be more likely to ask for support.

Importantly, as the integration of surgery into palliative care is considered, it is critical that the contributions of all disciplines be highlighted. Certainly, inclusion of the surgeon - the individual with the medical degree and expert surgical training - is the first step towards better integration. However, the expertise and experience of surgical nurses, surgical residents and other surgical assistants, and perioperative specialists such as anesthesiologists and anesthetists should not be overlooked. Just like the provision of full-service palliative care takes a village, the integration of surgery into that model requires many members of the village too.

Despite the fact that palliative surgery has long been known to play a crucial role in the optimal management of many patients with cancer and other chronic illnesses, it remains poorly integrated into the palliative care continuum at most institutions. This problem can be addressed, in part, by the seamless integration of palliative surgery into the palliative care paradigm. Essential to this model is the involvement of surgeons and surgical team members with interest and expertise in palliative surgery in the multidisciplinary care team. Postoperative and discharge planning should begin prior to surgery. Importantly, there should be oversight of quality, clinical effectiveness, and cost-effectiveness of the entire inpatient and outpatient continuum of palliative surgical care. Moving forward, one measure of the quality of palliative care programs should be the degree of integration of multidisciplinary care, including the seamless incorporation of palliative surgery services.

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Received January 31, 2012; **Accepted** February 01, 2012; **Published** February 06, 2012

Citation: Rialon KL, Abernethy AP, Mosca PJ (2012) Integration of Palliative Surgery into the Palliative Care Delivery Team. J Palliative Care Med 2:e115. doi:10.4172/2165-7386.1000e115

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