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"Aren't Surgery and Palliative Care Kind of Opposites?"

Myrick C. Shinall Jr, MD, PhD

Abstract

Surgery is often considered one of the most aggressive forms of medical care. Palliative care, on the other hand, usually focuses on eliminating aggressive forms of medical care in the name of patient comfort. This article explores the seeming incongruity between surgery and palliative care, conditions in which surgery and palliation coexist, and further integration of surgery and palliation.

Glad You Asked!

When I was a general surgery chief resident, I scrubbed a concurrent case with one of my orthopedic surgery colleagues. We chatted, discussing our postresidency plans. When I told him that I was enrolling in a fellowship in hospice and palliative medicine, he asked, "Aren't surgery and palliative care kind of opposites?" This was a reasonable question. After all, surgery is typically intensive and invasive, and palliative care typically seeks to eliminate unwanted, ineffective, intensive, and invasive interventions. So how to explain to my friend (and myself) that I wanted to practice surgery and palliative care?

Before addressing how palliation fits with surgery or other intensive or invasive interventions, a few terms need clarification. *Palliative* is derived from a Latin word meaning "to cloak" and refers to interventions that aim to mitigate symptoms without curing underlying disease.[1] *Palliative care* involves alleviating suffering and improving quality of life for patients with serious underlying diseases.[2] Palliative care is a necessary skill set for anyone caring for patients with serious illnesses, and some physicians, like me, train and become board-certified in hospice and palliative medicine so that we can bring expert palliation to patients whose cases are especially complex. Expert palliation involves helping patients avoid intensive interventions that do not serve their goals and that are accompanied by unpleasant side effects (eg, pain, fatigue, or other demands on patients' remaining time). Importantly, however, there is no single definition of *intensive*, nor is it always the case that effective palliation means foregoing some intensive interventions.

This opposition between palliation and surgery is not intrinsic but rather is coincidental in situations in which palliation is most routinely deployed. *Intensity* describes the nature of an intervention, specifically how it affects a patient receiving it. *Palliation* describes an intervention's aim not to cure but to reduce suffering. In short, palliation is an end, and intensity is a means. Although the ends of surgery suggest which means are

appropriate for achieving those ends, so do particular circumstances of a patient's case. Surgery and other intensive interventions are usually inappropriate means for end-of-life palliation because there is simply not enough time for a patient to recover or to benefit. A surgery likely to reduce suffering in a month is not useful to a patient likely to die this week.

Intensive Palliation

End-of-life scenarios can appear deceptively simple to some clinicians, particularly if their understanding of palliation is that it eliminates intensive therapies from a patient's care plan. But, in any given case, moving backward in time from the end of life to the inception of a condition requiring palliation can confound this limited understanding. Consider a patient who is living with, say, peripheral arterial disease that constricts his distal leg blood flow such that walking becomes nearly impossible due to claudication. A vascular surgeon who performs an endarterectomy or lower extremity bypass to relieve such life-limiting claudication does not cure this patient's underlying peripheral arterial disease but does help him walk without pain.[3] Similarly, the absence of effective esophageal peristalsis renders a patient with achalasia miserable with dysphagia. A surgeon who performs a Heller myotomy for this patient does not restore normal peristalsis but helps her to swallow more comfortably.[4] Neither surgery cures the underlying disease, but both alleviate disabling symptoms and restore some function; they are palliative surgeries and should be discussed in those terms, even if only to augment explanation of these surgeries as treatments for these incurable diseases. The upshot of these examples is that *surgical palliation* is not an oxymoron.

Although it's true that intensive surgical intervention cannot effectively palliate in some cases, the trick is to judge in which circumstances it will do so. As in the cases just described, when we move further back in time from the end of life to a time when a patient with a fatal, incurable disease (such as a malignant bowel obstruction) still has time to live, making judgments about whether a patient will live long enough to recover from an operation and enjoy its benefits is fraught with uncertainties—about survivability, the possibility of life extension or risk of death hastening, and the degree to which symptoms can be managed surgically or medically—that certainly justify the need for fellowship-level training. Deciding whether and when to offer a palliative surgical option also requires having good data to inform the decision[5] and the skill to apply that data and to discuss possible outcomes with a patient in a given case.

Palliative Surgical Metrics

The lack of data is only one challenge in palliative surgical practice. Another is that typical measures of success and failure in both surgery and palliative care can make it harder to apply surgical solutions to palliative problems.[6] Surgical success has typically been measured in terms of the absence of complications and their consequences, including postoperative death. Patient-reported outcomes (eg, about symptom burden and function) have not counted for much until recently.[7] Yet traditional morbidity and mortality metrics are not well-suited to evaluate palliative surgical interventions' success. What is more, palliative care is typically evaluated in terms of the degree to which intensive, expensive interventions are eliminated from patients' care plans. But for patients like those just described, surgical palliation will increase the cost and intensity of care. Surgery entails incursion of operating room fees, costs of postoperative hospitalization, and payment to clinical staff. In sum, successful palliation of a terminally ill patient will likely appear as a failure until metrics are developed, integrated into practice, and updated to meet the needs of the field and of patients.

Conclusion

We can now see why my orthopedic colleague's assumption of a conflict between palliative care and surgery was well-founded. The ways that both specialties have conceived of their roles and what constitutes success and failure make it natural to see them as opposites. Nevertheless, I hope to have shown here how palliation can be surgical and intensive, even aggressive. Recognizing when surgery is the best means for alleviating a patient's suffering should be a major priority in both surgery and palliative care.

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Myrick C. Shinall Jr, MD, PhD is an assistant professor of surgery and medicine at Vanderbilt University Medical Center in Nashville, Tennessee, where he is also a faculty member in Vanderbilt's Center for Biomedical Ethics and Society. Board-certified in surgery and palliative and hospice medicine, Dr Shinall practices general surgery and palliative care consultation, and his research focuses on palliative interventions for surgical patients.

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