

Preface



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Guest Editors

AN OTOLARYNGOLOGIST WITH AN INTEREST IN PALLIATIVE CARE

Otolaryngologists do not ordinarily think of themselves as providers of palliative care. This may be more related to how we think about what we do rather than to the current existing and widely accepted concept of what actually constitutes palliative care. In this edition of the *Otolaryngology Clinics of North America*, the scope of palliative care is viewed as being far wider than simply care for the dying patient. In the last few decades, while the scope of otolaryngology–head and neck surgery has been widening significantly, the scope of palliative care has become continually more expansive, and *palliative medicine* has become now a distinct medical specialty officially recognized by the American Board of Medical Specialties.

For sure, a delightful aspect of practicing otolaryngology–head and neck surgery flows from the sense that so many patients seeking otolaryngic care can benefit greatly from the array of medical and surgical interventions that we have to offer. The applications of laser technology, the advent of cochlear implants, the ability to do sinus surgery using endoscopes, and new minimally invasive approaches to neck surgery, including thyroidectomy, along with the concomitant continual introduction of newer and more effective medications, has enabled the otolaryngologist of today to do more than ever before to help patients with otolaryngic disorders, including those with cancer of the head and neck. Certainly, restoring normal hearing with a stapedectomy must be one of the most rewarding experiences any surgeon can have. Similarly, inserting a cochlear implant and watching a deaf patient hear again or watching a congenitally deaf child hear for the first time can be an exhilarating experience for both the patient and his or her physician. Excising a cancerous oral cavity lesion and artfully reconstructing the surgical defect is both challenging and deeply satisfying especially when the outcome for the patient appears to be good. Even simply removing nasal polyps, inserting tubes in a child's ears, and removing tonsils and adenoids can make the kinds of differences in the lives of patients that give the surgeon a great sense of accomplishment. Thus, in general, otolaryngologists become accustomed to helping patients, often quickly seeing the tangible benefits of their work perhaps in an

improved audiogram, an improved postoperative sinus computed tomography scan, or in declaring a patient cured of cancer many years after an extirpative surgery. Nonetheless, every otolaryngologist knows that not all patients improve after a specific medical therapy has been tried or surgery has been done. We have successes, and we also encounter frustrations when patients continue to have troublesome symptoms despite having received treatment. Although we have become accustomed to seeing the successful outcome of the treatments we routinely provide, every experienced otolaryngologist knows that our scope of practice includes the management of disorders for which there really is no universally effective treatment, and some of our patients with cancer will not survive despite our valiant efforts.

This edition of the *Otolaryngology Clinics of North America* has been prepared to provide information on how to manage those patients who have otolaryngic disorders that cannot be completely fixed, eradicated, or cured. The purpose of providing the information in this edition is to enlighten the otolaryngologist about how to care for patients for whom medical or surgical management cannot totally alleviate symptoms or achieve a cure. After all, we have to admit to ourselves and to our patients that we do not have a cure for tinnitus nor can we stop the progressive hearing loss that we define as presbycusis. Even though we do endoscopic sinus surgery, many patients with chronic sinus disease continue to have nasal obstruction and rhinorrhea after surgery, and some patients who have had excision of cancer of the head and neck have persistent or recurrent disease. In this volume, the reader will learn how those who have experience with various aspects of otolaryngology deal with the patients who need medical management directed at minimizing symptoms, coping with chronic conditions, and alleviating pain and suffering rather than aiming for complete cure. Palliative care has become a distinct medical subspecialty, and the time has come for otolaryngologists to know about the aspects of palliative care that are pertinent to the practice of otolaryngology–head and neck surgery.

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A SURGEON NOW BOARD CERTIFIED IN PALLIATIVE CARE

I am often asked, “How did you, a surgeon, become interested in palliative care?” There were many beginnings to my work in hospice and palliative care that occurred during my training and earlier surgical practice that I never appreciated until recently. Time has allowed me to see increasingly more the fundamental similarities of surgical and palliative care instead of the distracting and more superficial differences. Years before I had heard of palliative care or had any direct contact with hospice patients, I was involved in the care of patients with progressive, incurable, and life-limiting illness. In many of these cases, such as in trauma and critical care, the circumstances were acute and required immediate and decisive intervention. Like most surgeons and surgeons-in-training, I was proud of the expediency and effectiveness with which I could intervene on a patient’s behalf in life-threatening situations; however, I felt equally fulfilled on occasions when comforting a distressed patient, whether reassuring a young woman with

a fibroadenoma of the breast or counseling a cancer patient facing approaching and unavoidable demise. I learned from fatally burned patients, geriatric patients with overwhelming abdominal sepsis, and infants with catastrophic congenital anomalies and neonatal conditions that hoping for a good prognosis or intervening to improve it was too-limiting a perspective for much of the spectrum of surgical care. Saving life and saving hope are no longer synonymous in a time when the definition of life, itself, has become so biologically, socially, and spiritually complex. Saving life is not necessary for the salvation of hope as long as hope, itself, can be redefined. Closely related to the preservation of hope is the cardinal principal of nonabandonment. Surgeons have always enjoyed the moral pride that comes by standing in the patient's corner when all seemed lost to the patient, his family, and even our colleagues. I believe it is the premier value we as surgeons place upon the virtue of nonabandonment that makes palliative care so relevant to us and makes it so fitting that we become more active in its development as a medical field.

I believe that a fundamental shift in our orientation to the focus of care will be necessary to extend the reach of surgical care to the complete spectrum of illness. In fact, the treatment of illness rather than disease is the point of departure from the traditional biophysical model of orientation of care to organ systems. Disease occurs in organs; illness, which is the individual's experience of disease, occurs in people. Should the shift in orientation from disease to illness occur, head and neck surgeons of the future may join the fortunate ones of the past and present to see themselves more broadly as specialists in the care of persons afflicted with diseases of the head and neck, instead of mere specialists in the surgical treatment of diseases of the head and neck.

Ten years ago, when sharing my accumulating experience in hospice and palliative care with fellow surgeons and surgical residents, I recognized that transforming surgery from treatment of disease to the treatment of illness would be as daunting a task as surgeons overcoming avoidance or outright denial of death in their practices.

It seemed ironic to me when a surgeon who encountered death in patients from trauma on at least a weekly basis told me once "I can't imagine how you can deal with death and dying." The uneasiness of surgeons' acceptance of the patient-centered (illness, not disease, orientation) approach to care and the acceptance of death as a natural sequel and precursor to life are the two main psychological barriers to their unconditional acceptance of palliative care as an essential component of surgical care.

The American Board of Surgery was one of the sponsoring boards of the American Board of Medical Specialties' (ABMS) newly formed Board of Hospice and Palliative Medicine. The first certifying examination of the new board will be given in October 2008. Through the American Board of Surgery, otolaryngologists can seek ABMS certification in hospice and palliative medicine. Even if the number of potentially interested otolaryngologists is quite small, the potential impact of this group could be considerable given the early stage of evolution the field and the growing general interest in quality-of-life outcomes in surgical practice. I was certified by the previous American Board of Hospice and Palliative Medicine during its first year of certifying exams in 1997 with another surgeon, Robert Milch, who pioneered hospice care in Buffalo as early as the late 1970s. Other surgeons have since been certified, and awareness and interest in palliative care by surgeons has been documented in several studies.

Expanding our horizon for care will require new self-awareness, new language, and new skills, starting with the ability to communicate with patients in situations in which we had previously dreaded having to say anything. I have always believed that what we now describe as palliative care is not an exotic new idea, but it is an approach that has always been consistent with good surgical care. Recent attention to the compelling needs of the most desperately and terminally ill has only highlighted the many

unanswered needs of all patients. In time, the current period of growth in the field of palliative care may be looked back upon as the beginning (or return ?) of a more humane vision of *all* patient care. How ironic that the care of the hopeless and the previously abandoned could become the moral and scientific basis for the salvation of the soul and future of all surgery itself!

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