

Preface

Surgical Palliative Care



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Guest Editor

The surgeon can expect to encounter a substantial number of patients who have progressive, incurable disease, as the primary physician and as a consultant.

This issue acknowledges that the surgeon may have cognitive and psychologic barriers to his or her own confidence in addressing the problems that are associated with chronic progressive or terminal illness. The issue is offered as a point of reference for surgeons of different specialties who are seeking guidance for management of the salient problems that are encountered in palliative care, which is care whose goal is to relieve suffering and improve quality of life in the context of an individual's family and society. The three pillars of palliative care are: (1) pain and nonpain symptom management; (2) communication between patients, families, and care providers; and (3) continuity of care across a range of clinical settings and services [1]. The indications for palliative care are based on the need for these services, not prognosis.

The first article introduces the historic and philosophical background of palliative care, addresses palliative care's current status in the field of surgery, and concludes by affirming it as a durable philosophy of surgical care that is applicable across a wide spectrum of illnesses. Following this are articles that cover basic palliative care skills, such as chronic pain management and palliative care assessment. Several articles have been included to introduce the general surgeon to surgical palliative care techniques and concepts in other surgical subspecialties, including transplantation, which usually is not associated with palliative care. The issue concludes with an article on the status of palliative care education for

surgeons and surgeons-in-training. Although much of the material addresses oncologic illness, the principles and many of the interventions that are covered are clearly applicable to the much wider spectrum of illnesses.

Although the field of palliative care mostly has been developed by nonsurgeons, we face the same problems, and, in recent years, have begun to find our own collective voice in these matters. Palliative care challenges some of our most basic assumptions about the meaning of illness which leads us to ask new questions and discover new problems. As surgeons, we have a long tradition of service in the relief of suffering that precedes our recent accomplishments in eliminating disease. We can reclaim that tradition without compromising the bounty of life-saving innovation of the past half century. For a start, we must acknowledge the worthiness of a philosophy of care that represents a shift from elimination of disease to the unconditional relief of suffering and the affirmation of our patients' lives.

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Reference

- [1] Dunn GP. Restoring palliative care as a surgical tradition. *Bull Am Coll Surg* 2004;89(4):24.