

Who should decide where palliative surgery is right next step?

OCT 26, 2021

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Physicians too often regard palliative care as something reserved for dying patients, but it can benefit anyone living with a serious, complex illness. It is intended simply to improve a patient's health experience or quality of life, and it can even include surgery. But when it does involve surgery, physicians can be at odds over whether it's justifiable.

Following are highlights from an article published in the *AMA Journal of Ethics*[®] (@JournalofEthics) by Joshua T. Cohen, MD, a surgical resident, and Thomas J. Miner, MD, professor of surgery, at the Warren Alpert Medical School of Brown University.

Using a hypothetical case of a man with a slow-growing facial tumor that cannot be removed entirely and will eventually kill him, the authors explored how the patient and the physician can together determine whether surgery would be of high value and positive impact.

When surgery is an option

“If a patient with decision-making capacity insists on a treatment that is neither safe nor indicated, a clinician must refuse to provide the requested treatment,” the authors wrote. “Conversely, when a patient with decision-making capacity refuses treatment, a clinician must respect the patient's autonomy and cannot force a treatment on that patient.”

But these examples are extremes on the spectrum, and decision-making is more challenging in situations that fall in between. In addition, defining what is safe depends on how much risk the patient and physician are willing to accept.

Palliative surgery also adds a layer of complexity, the authors noted.

“The metrics that define successful outcomes often are more nuanced,” they wrote. “Traditional measures, including overall survival and disease-free survival, become secondary to symptom control

and quality of life.”

But it doesn't end there. Patients receiving palliative care also often need highly individualized treatment plans to address their complex disease processes.

“The choice of appropriate palliative therapy has become increasingly complex as the armamentarium of systemic therapies, minimally invasive surgeries, endoscopic procedures and percutaneous interventions for supportive care has expanded,” the authors wrote.

3 things to balance

The impact of surgery has to be evaluated, as “the degree of risk that patients at the end of life are willing to incur for a procedure they consider safe is variable and depends on their goals and preferences,” the authors wrote. “It can be useful to simplify these complex situations by considering what option will have the largest positive impact.”

The concept of value should be top of mind, they added, because “it determines the spectrum of options presented to a patient and can help guide decision making.”

They then pointed to these three key criteria for decision-making.

Symptom severity. Is the patient experiencing severe and pervasive symptoms that, if palliated, could have a positive impact on his life? For example, maybe the patient is housebound because of his condition and has needed repeated hospitalizations.

Goals of care. Knowing they might not survive much longer, patients might have end-of-life goals that affect decision-making. As a case in point, maybe the patient wants to visit a loved one.

The value of surgery. It could control the patient's symptoms and improve his quality of life. Depending on his condition, the patient may have time to enjoy the benefits of his operation, should he survive it and leave the hospital.

The costs of palliative surgery are not insignificant, however, and include resource utilization. Yet even with a long treatment duration, concerns about resource utilization probably should not supersede patient autonomy.

“Rather, health care financing concerns should be addressed at a policy and population, not a bedside, level.” the authors wrote.

The October 2021 issue of *AMA Journal of Ethics* further explores palliative surgery.