

Palliative care: from medicine to surgery, from adults to children, and from calls to action to community approaches to advanced care planning

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Submitted Jan 31, 2015. Accepted for publication Jan 31, 2015.

doi: 10.3978/j.issn.2224-5820.2015.02.02

View this article at: <http://dx.doi.org/10.3978/j.issn.2224-5820.2015.02.02>

This issue of *Annals of Palliative Medicine* marks the inaugural issue of the new and recurring column entitled, “Surgical Palliative Care” (1). This long-overdue column will focus on the role of surgeons in the field of palliative medicine. The scope of the column is beyond that of just palliative surgeries, and it includes novel surgical approaches and outcomes, significant advances in surgical palliative care, and reviews across the surgical disciplines in the field of palliative care. For the premier manuscript of the column, Geoffrey P. Dunn, MD, FACS, Surgical Palliative Care Subcommittee Chair of *Annals of Palliative Medicine*, authored an informative perspective piece on the evolution of surgery, palliative care, and the American College of Surgeons (2). Dunn details the role that the American College of Surgeons has played in advancing palliative care for patients receiving surgical care, and he accounts the inception of the Committee on Surgical Palliative Care (CSPC).

The CSPC has a mission to incorporate the precepts and techniques of palliative care into surgical clinical practice, education, research, and advocacy. CSPC has been instrumental in shaping the present role of surgical palliative care, and it has allowed for new pathways for surgical fellowship training in hospice and palliative medicine, identification of quality indicators of surgical palliative care, and incorporation of palliative surgical measures in the current morbidity and mortality surgical outcome measures (2). I look forward to the continued impressive contributions to the field of surgical palliative care by the CSPC, and to the *Annals of Palliative Medicine*

Surgical Palliative Care column contributions by Dunn and his colleagues.

While much of the content of *Annals of Palliative Medicine* is focus on adult medicine and end of life care for the elderly, robust palliative care services for children and the families of children facing grave diagnoses are critical and often overlooked. Al-Gharib *et al.* report in this issue of *Annals of Palliative Medicine* a novel investigation into the quality of pediatric care provided to children with malignancies (3). The authors conducted questionnaires using the Needs at End of Life Screening Tool (NEST) (4) on a sample of 85 children and adolescents receiving cancer treatment in a tertiary pediatric cancer center in Lebanon. Parents also completed the NEST questionnaire. Patients were least satisfied with participation in decision making, although adolescents aged 13-18 years reported a significantly greater involvement in decision making than children aged 7-12 years. In contrast, parents reported higher involvement in decision making, but they were least satisfied with securing a hospital bed and reported moderate financial hardship during their child’s illness (3). While this is a select patient population at a specialized Lebanese pediatric cancer center that has robust pediatric palliative care services, the findings in the study by Al-Gharib *et al.* underscore the importance of providing palliative care services that adequately address the needs of both the patient and the patient’s family and empowering patients with open communication and participation in decision making. These are basic pillars of palliative care that must apply to adults and children alike.

Also in this issue of *Annals of Palliative Medicine*, Bomba and Orem account the Greater Rochester area, New York response to the Institute of Medicine's call to action in 1997 (5) and the development of a community approach to advanced care planning. Their comprehensive paper (6) details the lessons learned from the development and implementation of New York's community approach to advanced care planning as a wellness initiative, and it describes the key components of the complementary programs Community Conversations on Compassionate Care (CCCC, an advanced directives program for all individuals 18 years of age and older or emancipated minors) and Medical Orders for Life-Sustaining Treatment (MOLST, a program for medical orders for life-sustaining treatment for seriously ill persons of all ages facing the end of life).

Bomba and Orem show how these programs and the larger advanced care planning initiatives have expanded throughout New York State to improve end of life care, and they provide objective measures supporting the value of CCCC and MOLST (6). Several key lessons can be gleaned from the implementation and triumphs of these programs that are certainly applicable to other states in the United States, as well as globally. Through this and other effective advanced care planning models, cultural change can be realized through advances in professional training, community education, system implementation, and continuous performance improvement focus on quality.

Lastly, patients with skin cancers, several lymphomas and leukemia like adult T-cell leukemia/lymphoma (7), mycosis fungoides, and angiosarcomas can present with or develop diffuse scalp manifestations of disease that are often highly symptomatic. For such diffuse presentation of disease causing pain or bleeding, total scalp irradiation can be an effective means to achieve symptomatic palliation. However, planning and delivery of total scalp irradiation is technically challenging, as it is difficult to achieve a homogenous irradiation dose to the entire curved scalp while avoiding

unnecessarily delivering irradiation to the underlying brain. In this issue of *Annals of Palliative Medicine*, Caivano and colleagues describe a novel electron-based treatment technique of delivering palliative total scalp irradiation that can be considered as a means to provide symptomatic control for patients with diffuse scalp involvement from cancer (8).

Acknowledgements

Disclosure: The author declares no conflict of interest.

References

1. Simone CB 2nd. Current focus and future advances for *Annals of Palliative Medicine*. *Ann Palliat Med* 2014;3:37-8.
2. Dunn GP. Surgery, palliative care, and the American College of Surgeons. *Ann Palliat Med* 2015;4:5-9.
3. Al-Gharib RM, Abu-Saad Huijjer H, Darwish H. Quality of care and relationships as reported by children with cancer and their parents. *Ann Palliat Med* 2015;4:22-31.
4. Emanuel LL, Alpert HR, Baldwin DC, et al. What terminally ill patients care about: toward a validated construct of patients' perspectives. *J Palliat Med* 2000;3:419-31.
5. Institute of Medicine (IOM). *Approaching Death: improving care at the end of life*. Washington, DC: National Academy Press, 1997.
6. Bomba PA, Orem K. Lessons learned from New York's community approach to advanced care planning and MOLST. *Ann Palliat Med* 2015;4:10-21.
7. Simone CB 2nd, Morris JC, Stewart DM, et al. Radiation therapy for the management of patients with HTLV-1-associated adult T-cell leukemia/lymphoma. *Blood* 2012;120:1816-9.
8. Caivano R, Fiorentino A, Pedicini P, et al. A radiotherapy technique for palliative total scalp irradiation. *Ann Palliat Med* 2015;4:35-8.

Cite this article as: Simone CB II. Palliative care: from medicine to surgery, from adults to children, and from calls to action to community approaches to advanced care planning. *Ann Palliat Med* 2015;4(1):1-2. doi: 10.3978/j.issn.2224-5820.2015.02.02