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The Importance of Advance Care Planning for Palliative Procedures

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Abstract

Palliative interventions for patients facing life-limiting illness can dramatically improve quality of life but also have the potential to engender further suffering. Providers across disciplines must set aside time for advance care planning with patients and their surrogate decision makers prior to any palliative procedure. These discussions should thoroughly explore patient expectations and hopes for surgery, address the possibility and acceptability of postoperative life-sustaining treatments, clarify perioperative code status, help surrogates prepare for their role, and be documented in a central, accessible location in the medical record. Together, these components will maximize our ability to reduce conflict, surrogate burden, and provide goal-concordant care for patients in the last stages of illness.

Keywords: Surgery; Quality of life; Palliative care

Introduction

Though an advance care plan can be developed at any stage of life, it assumes particular importance and utility for patients with life-limiting illnesses given their risk for deterioration and ensuing need for end-of-life decision making. Patients with advanced disease who seek palliative operations also face additional risks from postoperative complications, including loss of decision-making capacity, accelerated functional and cognitive decline, or death. Such outcomes are frequently at odds with the goal of palliative procedures: to relieve symptoms caused by an underlying illness and improve quality of life. To address this tension, clear and compassionate preoperative communication between providers, patients, and their surrogate decision makers is needed. Discussions preceding palliative operations are unique opportunities to initiate, revisit, or revise a patient's advance care plan. When revised to address specific procedural considerations, advance care plans can help ensure alignment of patient goals with the proposed procedure and potential subsequent postoperative treatments, as well as clarify a path forward if unanticipated outcomes make preoperative goals unrealistic.

Clarify Values and Care Preferences

The basic components of advance care planning prior to a palliative procedure are common to those of any high-risk procedure. However, a more tailored exploration of certain elements is required for patients seeking palliative operations. Additionally, providers should specifically address unanticipated perioperative courses and review the accuracy and applicability of any durable power of attorney forms, advance directives, or physician treatment orders (i.e. POLST or code status) during a patient's perioperative course. These documents should be leveraged to guide goals of care discussions and can also help prepare surrogates for their role.

Goals of surgery

A patient's goals and hopes for surgery should be elicited. These often include the unique goals of amelioration of uncomfortable symptoms, optimizing length of time at home with loved ones, or improvement in functional or nutritional status. In contrast to patients seeking a curative operation, who may be willing to trade some reduction in quality of life for disease eradication, quality of life considerations generally assume paramount importance for a patient with life-limiting illness. Therefore, it is crucial to preoperatively clarify a patient's goals for surgery, consider the feasibility and availability of alternative nonsurgical options that may achieve these goals with less risk or harm to the patient, and anticipate a procedure's ability to provide the patient with their desired outcomes.

Perioperative code status

As many have diminished physiologic reserve, patients with an end-stage illness contemplating a palliative procedure may have a higher risk of complications from anesthesia, including the risk of cardiac arrest. A patient's perioperative code status must be discussed preoperatively. When patients have a documented Do-Not-Resuscitate (DNR) status, a clear discussion about their perioperative DNR status and the timing of any changes in this status is indicated. Some patients, for example, may agree to resuscitation when the underlying clinical condition is expected to be quickly and easily reversible, but not in situations that are likely to result in permanent neurologic impairment or dependence on life-sustaining technology. Others may consistently decline chest compressions, defibrillation, or even intubation at any time during their perioperative course, while others may request full attempts at resuscitation during their operation and in the immediate postoperative period. It is essential to document any modifications to a patient's DNR order in the medical record, communicate the plan for DNR status with all members of the operating room team, and ensure that all transfers of care include a plan for when the original DNR order will be reinstated.

Postoperative treatment scope

Given the high risk for morbidity and mortality after palliative operations [1,2] it is especially important to discuss the possibility of requiring invasive postoperative treatments such as mechanical ventilation, or procedures such as feeding tube placement. A previously completed advance directive may reflect a patient's wishes about life-sustaining treatments. In the absence of an advance directive, however, providers should not assume that by accepting surgical care patients implicitly agree to postoperative life-sustaining interventions. Rather,

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an important focus of these preoperative discussions should be whether patients have strong preferences about postoperative treatments they wish to avoid, or whether they are willing to endure some burdensome postoperative treatments in order to achieve their desired outcomes. In these latter situations, it is helpful to elicit which health states and valued life activities are most important to patients, such as communicating with loved ones, being free from pain, or being able to take part in social activities. By clarifying and documenting these values preoperatively, providers and families may be more easily able to place a proposed postoperative life-sustaining treatment in a value-based context; the burdens of any proposed life-sustaining treatment can be weighed against the likelihood that it may help achieve a previously identified acceptable postoperative health state.

Identify and Invite a Surrogate

Given the risk of cognitive decline and loss of decision-making capacity in the postoperative period, patients seeking a palliative procedure should identify a surrogate decision maker and be given the opportunity to have them present for these important goals of care discussions. If unable to be present, patients should be encouraged to discuss their treatment preferences with their surrogates. By participating in a patient's advance care planning, surrogates are more likely to understand a patient's treatment preferences and make informed, value-based decisions about their loved one's care when needed. By preparing surrogates for this role, the burden of decision-making can be lifted and they more likely to experience less decisional conflict, greater satisfaction, and higher consolation in end-of-life settings [3].

Update and Supplement Documentation

In order to be clinically useful throughout the perioperative period, these goals of care discussions must be documented consistently and clearly in an accessible location in the medical record, including the preferred surrogate decision maker and any updated advance directives. Through sound documentation, patient goals and preferences can be reviewed when needed in the perioperative period by the many providers involved in their care. Inadequate documentation could lead to unwanted postoperative treatment and conflict between providers or surrogate decision-makers, especially if there are inconsistencies between a patient's stated treatment preferences around the time of surgery and an existing advance directive.

Engage a Multidisciplinary Team

Surgeons are uniquely positioned to lead these advance care planning discussions. One study has found that the majority of patients prefer to have these discussions with their surgeon when contemplating an operation [4]. However, usual workflows are not designed to accommodate the complex palliative care needs of patients with end-stage illness seeking palliative procedures. If a patient is not already under the care of a palliative care clinician, a palliative care referral should be strongly considered prior to any intervention. Palliative care is underutilized by surgical patients with serious illness [5]. Dedicated attention by a palliative care specialist will ensure that these patients receive optimal perioperative care, including complex symptom and pain management, assistance with clarifying treatment goals, family support, and expert transitions of care at the end-of-life. Indeed, wide engagement of a multidisciplinary team consisting of surgeons, palliative care physicians, anesthesiologists, perioperative medicine clinicians, primary care providers, and other medical specialists will optimize planning for patients undergoing a palliative procedure.

Surgical interventions for patients facing life-limiting disease can dramatically improve quality of life but also have the potential to engender further suffering. Providers across disciplines must set aside time for advance care planning and goals of care discussions prior to any palliative intervention. These discussions should thoroughly explore patient expectations and hopes for surgery and the health states and valued life activities that are most important to patients. They should include an explanation of possible complications and specifically address the possibility and acceptability to the patient of postoperative life-sustaining treatment. Perioperative code status must be clarified and communicated with members of the perioperative team. Existing advance directives should be leveraged to guide these discussions and steps taken to help surrogates prepare for their role. All advance care planning must also be documented in a central, accessible location in the medical record. Taken together, these components will maximize our ability to reduce conflict, surrogate burden, and provide goal-concordant care for patients in the last stages of illness.

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