Surgical Palliative Care

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Objectives

- Define surgical palliative care
- Highlight areas of controversy
  - Hope
  - Palliative care lengthening life
  - 30 day mortality problem/quality metrics
- Describe strategies to improve end of life care
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
...an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial, and spiritual problems.

It is offered simultaneously with all other appropriate medical treatment.
Surgical palliative care

- Surgical procedures for palliation
  - Gastrostomy tube
  - Surgical bypass
  - Reduction of tumor burden
  - Tracheostomy

- Treatment of suffering and promotion of quality of life for surgical patients who are seriously or terminally ill
Trajectory of illness

CANCER
CHF, dementia
unexpected death
unexpected event

Function


Covinsky et al. JAGS 2003
Lynn & Adamson RAND 2003
Grief response

- "normal" grief
  - Intense emotions
    - Histrionic
    - Stoic
    - Denial
  - Physical symptoms
  - Review relationship
  - 6-10 weeks, up to 1 year
Grief response

- Complicated grief
  - Chronic
  - Delayed
  - Exaggerated
  - Masked
Grief response

- Nature of relationship between mourner and deceased
- Mode of death
- Previous history of loss
- Personality of mourner
- Social factors
- Concurrent stressors

High risk
Grief response

- Preparation, anticipation
- Encourage communication
- Family presence at/near time of death
- Encourage reminiscence
- Normalize grief expression/behavior
# Perspectives on Hope

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Olsman, Palliative Medicine, April 2013
Increasing life expectancy

150 patients with NSCLC

- Standard oncology care
  - Met with palliative care when patient/family requested

- Integrated palliative care
  - Met with palliative care within 3 months of dx and at least monthly thereafter
Change in QOL from Baseline to 12 Weeks

FACT-Lung

Study Arm
Mean change Early Palliative Care = + 4.2
Mean change Standard Care = - 0.4
$p=0.09$

FACT-Lung TOI

Study Arm
Mean change Early Palliative Care = + 2.3
Mean change Standard Care = - 2.3
$p=0.04$

Temel - NEJM 2010, ASCO 2010
Survival Analysis

MedIAN Survival
Early palliative care  11.6 mo
Standard care  8.9 mo
p=0.02

Controlling for age, gender and PS, adjusted HR=0.59 (0.40-0.88), p=0.01

Temel - NEJM 2010, ASCO 2010
How does this happen?

- Symptom control
- Psychosocial support
- Communication
  - Tell – ask – tell, tell, tell
  - Ask – tell – ask
- Patient-centered care = control
Palliative Care Bundle

- Adequate pain relief
- Adequate relief of anxiety
- Code status known
- Advance directives known
- Social services, pastoral care involved
- GI symptoms controlled
- Dyspnea relieved
- Family comfort addressed
- Goals of care known
Discussing treatment goals

- What does the patient know?
- Review condition and prognosis
- Invite questions
- Discuss potential goals
- Invite questions, allow time to reflect
- Decide if related issues of treatment withdrawal need to be discussed
“What do you understand about your condition?”

“Although I can’t give you an exact time, in general patients with your condition live X weeks (months) to Y weeks (months)”

“It seems like you are having a hard time deciding between X and Y”
Statements to Avoid

- What would you like us to do if ..... 
- The choice is yours—we can keep doing what we are doing or stop everything 
- There is nothing left to do 

Why?

Shifts total burden of responsibility/guilt from the MD to the patient/family
Routine family meetings

- Diagnosis based
- Time based
  - > 3 day ICU stay
  - Initial meeting scheduled
  - 48-72 hour formal briefings
  - More often or comprehensive if needed
30-day mortality problem

- Quality metric, reportable
- Withdrawal of life-sustaining care
  - Day 29 = good care, poor quality
  - Day 31 = good care, good quality
- Withdrawal of life-sustaining care--NTDB
  - In-hospital hospice = good care, poor quality
  - Out of hospital hospice = good care, good quality
Quality measures

- Patients Admitted to ICU who have care preferences documented (NQF 1626)
  
  **Description:** Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.

- **Numerator:** Patients in the denominator who had their care preferences documents within 48 hours of ICU admission or have documentation of why not done.

- **Denominator:** All vulnerable adults admitted to ICU who survive at least 48 hours after ICU admission
Quality metrics

- Giving bad news
- Pain control
- Family meetings
- DNR orders
- Goals of care discussions
- Effect on mortality rate

- Bereavement survey
- Avatar, HCAHPS, audit
- Electronic template, number
- Denominator problem
- Adjusted mortality rate
Educational Outcomes

- Prior palliative care experience strongest predictor of outcome
- Didactic intervention alone little influence
- Clinical experiences key

Old cure/care model

Life
Prolonging Care

Palliative/Hospice Care

Disease Progression

DEATH
Palliative Care

No Giving up
New cure/care model

Disease Modifying Therapy
Curative, or restorative intent

Life Closure

Diagnosis Palliative Care Hospice

Death & Bereavement

NHWG; Adapted from work of the Canadian Palliative Care Association & Frank Ferris, MD
Summary

- Palliative care ≠ end of life care
  - May increase length AND quality of life
- Surgical palliation good option
  - Consistent with goals of care
- Quality metrics important
  - Mortality tricky
- Palliative care = good surgical care