Editorial

Perioperative goal-setting consultations by surgical colleagues: a new model for supporting patients, families, and surgeons in shared decision making

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Abstract: Patients with postoperative complications are often subjected to prolonged life-sustaining treatment based on erroneous assumptions about their goals of care. Shared decision making (SDM) is an evidence-based approach that helps ensure patients' wishes and values are honored in their course of treatment. Perioperative palliative care can help create goal-concordant trajectories of care for high risk, seriously ill, or complicated patients, through sophisticated prognostication, higher-level communication, and recommendations based on the best available evidence and patients' stated goals and priorities. Here, we present a surgeon-to-surgeon consultative model that surmounts many barriers to perioperative palliative care consultation and, as illustrated in the cases presented herein, offers profound and unique benefits for patients, families, and surgeons alike. While the support of a surgical colleague with palliative care skills can be helpful postoperatively in the setting of unanticipated outcomes or prolonged recovery, it is particularly beneficial when accessed preoperatively for the purposes of goal-concordant decision making and advance care planning. We encourage both individuals and professional societies to develop and expand the niche for surgeons interested in assisting with goal setting and SDM for patients on a consultative basis, particularly in the preoperative period.

Keywords: Goals of care; palliative care; perioperative; shared decision making (SDM); surgeon; surgery; surgical patients

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Patients with postoperative complications are often subjected to prolonged life-sustaining treatment. A case in point is that of a middle-aged bed-bound woman with end-stage renal disease, morbid obesity, and malnutrition who consulted a surgeon for elective repair of her large ventral hernia with multiple enteroatmospheric fistulae. In the spirit of informed consent, the surgeon preoperatively discussed with the patient and her extended family expectations for a prolonged recovery and multiple complications, and the significant risk of mortality. The patient decided to proceed with surgery, and not unexpectedly, she suffered multiple postoperative complications requiring ongoing intensive care. Concern arose as to whether ongoing aggressive treatment was in her best interest. The intensivists and residents caring for her invoked futility, while the attending surgeon expressed his conviction: "*I don't want to give up on her yet; I think we can pull her out of this.*"

This scenario is all too common, and represents a pitfall of modern surgical treatment: just because we can does not mean that we should. In fact, death is not uniformly perceived as the worst possible outcome by patients (1), and therefore prolonged high-intensity treatment may not be in line with patient goals. Thankfully, in this case, the patient was "rescued"—but not in the manner one might think. Instead, the lack of consensus among the interdisciplinary team prompted a surgeon-to-surgeon consultation with a

colleague specializing in communication and navigating end-of-life issues in surgery. At a family meeting during which both surgeons and a palliative care counselor were also present, clear goals were elucidated. Among these, the patient's desire to return to functional independence emerged as her sole motivation for pursuing the operation, despite its substantial risks. By clearly establishing this goal and the fact that it would be impossible to achieve given the gravity of the patient's clinical scenario, the meeting resulted in a unanimous decision on the part of the patient's family and all involved clinicians to withdraw life-sustaining treatment and transition to palliative measures only. The patient died comfortably several days later, with the family and primary surgeon at peace with her death, the decisions made, and the conduct of her care.

Erroneous assumptions about patients' goals often drive prolonged life-sustaining treatment for patients with postoperative complications. This failure to provide patient-centered care can be preempted by effective preoperative communication, in which "success" is defined in explicit terms sensitive to patient's unique goals and values. Such goal-setting conversations enrich the process of shared decision making (SDM) in surgery, whereby patients, their surrogates, and their surgeons work closely together to make treatment decisions, both pre- and post-operatively. SDM is often depicted as existing on the spectrum between autonomy and paternalism measured by the patient's desire and preparedness for self-determination and the surgeon's comfort with individualizing treatment plans to patient-specific values and desires. The construct of SDM has been shown to improve patient and family outcomes for critically ill patients and minimize treatment that is highly burdensome, non-beneficial, and/or poorly aligned with patient preferences and values. Indeed, SDM is "considered the standard of care for making decisions regarding life-sustaining therapy" in the intensive care unit (ICU) (2), and aligning treatment with patient values and preferences is a top national priority (3).

While the appeal of this model is clear, surgeons, patients, and surrogate decision-makers face multiple challenges when it comes to implementing SDM in practice, especially in high-stakes surgical scenarios. Particularly in the acute setting, surgeons encounter insufficient time, poor prognostic accuracy, and lack of confidence and skill in nuanced patient-centered communication techniques. Surgeons are also subject to cultural factors that can interfere with objective assessment of and fidelity to patient goals and preferences in the face of postoperative complications. These include the phenomenon of "surgical buy-in", whereby the surgeon assumes that a patient agreeing to an operation is also consigning himself or herself to the full range of aggressive postoperative care, as well as deep feelings of personal responsibility and guilt associated with poor outcomes (4-7). Patients may be reluctant to discuss end-of-life care, and lack the preparation or knowledge to comfortably and effectively exercise autonomy in SDM (6). Surrogate decision-makers are often ill-prepared to apply substituted judgment or the best interest standard to decision making on behalf of the patient. They may pursue nonbeneficial treatment because they are unaware of the patient's preferences, or are grappling with their own complex emotions. And all three parties, especially in "crisis" situations, may be biased toward the sometimes misguided view that medical "help" comes in the form of a "fix", a one-and-done solution to a problem that can be definitively solved. The result is often an incapacitated patient facing a prolonged critical illness, a family burdened with unexpected decision-making responsibilities, and a surgeon who sees no other possibility than continued aggressive life-sustaining care (2).

Perioperative palliative care consultation can help facilitate SDM and negotiate many of these challenges. The specialized knowledge and skill sets of palliative care practitioners (physicians, nurses, counselors, and others) are developed to facilitate the elicitation of patient values and preferences in a meaningful and clinically relevant manner. Palliative care expertise can help formulate clear treatment goals aligned with these values and preferences, and prognosticate accurately to be able to weigh the relative benefits and burdens of various treatment options, are imperatives for selecting which among those options is best for each patient. While there is no widely accepted consensus on "triggers" for palliative care consultation as a standard of care in surgery, benefits are beginning to emerge in the literature. In a recent landmark study, Ernst *et al.* demonstrated that preoperative palliative care consultations triggered by the results of a system-wide frailty screening program resulted in significant reductions in surgical mortality (8). Importantly, this study highlights the fact that appropriate triggers may include not only nature of the surgical problem and the proposed surgical procedure, but also the patient's underlying comorbidities, including cognitive and functional deficits and decline.

Surgical palliative care experts offer unique contributions to the care of surgical patients. While we believe that palliative care specialists of all backgrounds can and do make

tremendously valuable contributions to the care of surgical patients, there are situations in which a surgical colleague is uniquely poised among other palliative care practitioners to guide decision making. In particular, a surgeon can deliver an assessment grounded in robust fundamental knowledge of surgical indications, risks, benefits, and outcomes. And while we believe that many of the prognostication, communication, and patient management skills required for the palliative care of surgical patients represent core competencies for all surgeons—and need to be fostered as such by educational objectives and curricula—we also recognize that there are occasions in which the "primary palliative care" capabilities of the average surgeon are insufficient to meet patient needs.

At our Department of Surgery, we have capitalized on the unique composition of our surgical faculty to establish a novel and surgeon-friendly consultative model for SDM perioperatively. Currently we harbor three trauma surgeons board-certified in hospice and palliative medicine, and additional faculty with specialized interest and education in this area. Two of these surgeons are available for formal perioperative consultation to establish goals of care and participate in SDM concerning high stakes surgical problems. In particular, patients being considered for high risk oncologic resections may be referred for preoperative outpatient consultation. Triggers include those who are to undergo esophagectomy, pancreatectomy, complex hepatobiliary resections, pelvic exenteration, or heated intraperitoneal chemotherapy (HIPEC).

This important collaborative effort has the potential to greatly benefit patients facing high-stakes surgery. One such patient was a 62-year-old woman with stage IV colon cancer deemed inoperable at an outside hospital. A surgeon at our institution offered her pelvic exenteration and HIPEC, and consulted a surgical colleague board certified in hospice and palliative medicine for preoperative SDM. During a preoperative outpatient visit, the consulting surgeon was able to answer detailed questions about the surgery itself, as well as the anticipated post-operative course, ICU care and pain management, all of which were a source of anxiety and concern for the patient. The patient declared that after surgery, she hoped to return to a functionally active and independent life at home, enjoying the company of her husband, son, and grandchildren. She explained that she was interested in any interventions that would allow her to move forward in her care towards her goal of returning home, but understood that she might require lengthy hospitalization and a few weeks of rehabilitation before returning home after surgery. She specified that she would accept a tracheostomy and a feeding tube if they were to be temporary, but not if there were no hope of returning to an independent functional status at home. She explicitly stated that she did not wish to live indefinitely in a skilled nursing facility, and emphasized repeatedly that her goals were for "quality of life, not quantity of life". Further, she named her son and not her husband as her health care proxy, stating that her husband would "be too emotional to make reasonable decisions".

The patient's family was present for this consultative session, and these declarative wishes helped to direct her post-operative care toward her goals. Post-operatively, the patient faced some challenges with pain control and frustration surrounding her relative weakness as she recovered from surgery. Based on her documented pre-operative discussion, the surgical team was better able to understand both her fears and motivations surrounding her recovery, and they worked closely with the patient toward the goal of getting her home. Further, should her disease progress such that independent life at home were no longer possible, the patient's wishes regarding end-of-life care as well as who should act as a surrogate are now well known to both her family and the care team.

Our surgeon-to-surgeon consultative model surmounts many barriers to perioperative palliative care consultation and offers profound benefits for patients, families, and surgeons alike. The proximity of palliative care expertise housed within a surgical practice mitigates the lack of exposure and education that prevents many surgeons from appreciating the availability of palliative care consultation and its relevance to perioperative decision making. By providing patients with improved access to these services, treatment plans and outcomes are more clearly aligned with preferences and values. In addition, the presence of a second surgeon—as opposed to the slow, quiet exit of the primary surgical team that all too often accompanies the trajectory of postoperative complications culminating in withdrawal of life support—permits families to understand paradigm shifts in patient treatment goals without experiencing a feeling of abandonment by the surgical team. Our model also addresses the reluctance of many surgeons to involve palliative care because of a perception that nonsurgical specialists lack insight into surgical procedures, complications, and decision making; indeed, there is a common sense among surgeons that those outside our professional tribe "don't speak our language". Inability for surgeons to identify with and feel supported by their

nonsurgical colleagues may speak to the unique palliative care needs of surgeons themselves, particularly when coping with the complex emotional responses associated with postoperative complications. Our consulting surgeons have derived great comfort and solace in the support of a fellow surgeon who gives permission to "let go" and legitimizes the cessation of continued high-intensity treatment-directed interventions when these are unlikely to advance the patient's goals, all within the context of a shared professional identity.

Several opportunities for continued growth and development exist in this nascent niche at the intersection between surgery and palliative care. And who better than surgeons to take an active role in promoting and defining best practices for prognostication, communication, and decision making for seriously ill patients perioperatively? The ability to deliver an assessment grounded in robust fundamental knowledge of surgical indications, risks, benefits, and outcomes has always been a core surgical competency, but as a field we are beginning to better understand the nuances of this deliberation as it is applied to patients with chronic comorbidities, frailty, and life-limiting illness. In particular, we face opportunities to facilitate access to palliative care consultation and informed goal setting and SDM in the acute surgical setting, and to streamline and integrate perioperative palliative care processes into the usual care workflow so that treatment delays are minimized. As a professional community, we also need to address surgeons' perceived loss of autonomy and ownership over the patient's trajectory of care, the perception that palliative care may interfere with hope or surgical "buy-in", and fear of the impact of palliative care-driven changes in postoperative management on outcomes including mortality. Surgeons interested and educated in the core principles of palliative care will be integral to filling many of these gaps.

Our model relies on the availability of surgeons with specialized knowledge in the prognostication and communication skill sets acquired through higher level training in palliative care. There are currently fewer than 100 surgeons nationally board-certified in hospice and palliative medicine (9). The recent creation of a fellowship training pathway for surgical residents will help ameliorate this dearth of surgeons with specialized palliative care expertise (10). We applaud the American College of Surgeons and the American Board of Surgery for supporting this effort, and eagerly eye progress toward the formalization of mid-career training tracks for established surgeons interested in obtaining additional specialty training or certification in hospice and palliative medicine (11,12). In the meantime, we will continue to develop, study, and promote the surgeon-to-surgeon perioperative consultative model, which we believe has the potential to greatly enhance the quality of the surgical experience for patients, families, and surgeons alike.

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Footnote

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