



# Surgical palliative care: filling the gaps

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Over the past 70 years there has been a shift in medicine away from paternalism towards shared patient decision-making (1). This effort to align interventions with patient preferences and values is the heart of palliative care, and many specialties have embraced palliative care as an effective tool to enhance shared patient decision-making, address symptom relief, navigate prognostic uncertainty and complex family and social dynamics, provide advance care planning (ACP), and offer caregiver support. Earlier integration of palliative care can decrease length of stay, improve communication, and enrich physical and emotional wellbeing (2-4). However, the surgical community has been slower to adopt the use of palliative care compared to its medical counterparts, and surgeons still struggle with the concept of palliative care and how it can benefit their patients. As surgeons, some of our reticence may stem from a deep-seated sense of ownership of our patients and the feeling that we do not want to “give up on them”, but also simply from a lack of understanding about what palliative care can offer and how to broach these complex topics with patients. Unfortunately, the data on palliative care use in the surgical arena are sparse, and surgeons and palliative care specialists alike need to understand where the knowledge gaps are in order to address them.

In the November edition of *Annals of Palliative Medicine*, Kopecky *et al.* provide a comprehensive narrative review of

the literature on palliative care use in surgical patients from 2016–2022 in the article entitled “*Palliative care interventions for surgical patients: a narrative review*” (5). This topic is both timely and highly relevant given the dearth of publications in the field. The review is an appropriate adjunct to Lilley *et al.*'s 2016 review and aims to align with published prioritized research goals in surgical palliative care: measuring outcomes that matter to patients, communication and decision-making, and delivery of palliative care to surgical patients (6,7).

In terms of measuring outcomes that patients value, much of the data in the review validate the idea that palliative care improves communication. The review finds that patients often fear debility and burdening loved ones rather than a lack of decision-making capacity. Patients and families are noted to have a very broad range of expectations around end-of-life discussions, further highlighting the complexities of these topics and the need for further research and adaptive frameworks.

In terms of communication and decision-making, the authors identify that there are frameworks in place for discussing ACP in the preoperative setting, ACP educational videos that patients find helpful, and findings that patients are more likely to have ACP paperwork complete if palliative care is involved preoperatively. However, how these factors translate into patient-centered outcomes is

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not known. Frameworks are also being implemented in unexpected, catastrophic illness (sudden advanced illness; SAI) to help providers steer these challenging conversations, but similarly, patient centered outcomes remain elusive. The findings demonstrate a significant need for further research, particularly on best practices for aligning surgical therapies with patient-oriented outcomes, as there are no studies identified that specifically address this fundamental underlying tenet of palliative care.

The studies characterized by delivery of palliative care to surgical patients overwhelmingly identify a lack of surgeon knowledge and comfort in palliative care. Fortunately, several of the investigations offer education and communication frameworks: including a set of core competencies for surgeons (8), a consensus definition of serious illness (9), evaluation of the use of Best-Case/Worst Case scenarios in surgical populations (10), and a pre-op framework for discussion with elderly patients (11). Given the evidence of surgeon discomfort with palliative care topics, approaches to build primary palliative care skills for surgeons and develop frameworks to guide conversations with patients are desperately needed.

This review provides a broader perspective on several of the relevant issues we are facing in surgical palliative care today. One of the fundamental needs in surgical palliative care is a shifting of the culture. Surgical trainees, when asked about the barriers to palliative care referrals, cite barriers such as difficulties with prognostication, communication barriers (with patients, families, and other providers), surgical hierarchy/getting permission from superiors, and surgeon mentality (12). All of these barriers contain some component of either surgeon resistance or difficulty with communication. Surgeons who are proponents of palliative care and palliative care specialists alike have a huge opportunity to educate both trainees and surgeons. The more we can “normalize” the use of both primary and specialty palliative care in the surgical population and provide surgeons with effective communication tools to employ, the more the culture will shift towards shared decision-making. Strategies to disseminate these frameworks and make them more easily accessible to surgeons are needed. More close collaboration between surgeons and palliative care specialists may be one of the answers to overcoming these obstacles.

One significant theme in Kopecky *et al.*'s review is the overall lack of patient-centered outcomes in the current literature. This deficiency is critical; not only are patient-centered outcomes the cornerstone of palliative care,

but clinicians must know which interventions are most effective in the surgical population in order to best serve their patients. Additionally, as a data-driven species, many surgeons want to see evidence of success (or lack of harm) before employing an intervention, particularly if those surgeons have preconceived biases or skepticisms. Future study should ideally prioritize patient-centered outcomes, including more concrete measures such as healthcare utilization at the end of life, length of stay, discharge disposition, functional status, pain and symptom scores, well-being indices, as well as patient and family perceptions. Surgeons would find mortality data useful as well. In this review only one study evaluating “triggers” for palliative care consultation focuses on patient-centered outcomes, demonstrating a reduction in healthcare utilization at the end-of-life in trauma patients (13). Trigger tools could be potentially useful in the surgical population given some surgeons' reticence to consult palliative care and should be explored further. However, the outcomes should be meaningful to the patients and align with their values.

Additional future research emphasized by this review includes identifying the ideal timepoint to apply palliative care principles in the surgical patient. In the preoperative setting, clinicians may be able to have more extensive ACP discussions, however the scenarios are often hypothetical, and patients may not have a realistic idea of all the potential outcomes. At the time of acute illness, the stress and high intensity of the situation might skew decision-making. Despite these challenges, serious illness conversations in this population can help patients and families recognize uncertainty, and significantly improve caregiver distress when things do not go as planned. Timing and frequency of discussions need to be explored, as well as whether surgeons or palliative care specialists should be broaching the topic. Future work should also investigate the presence of inequities in palliative care delivery. There are few studies examining racial/ethnic and gender disparities in palliative care in the surgical population. Some data in the general medical population suggest that disparities do exist in terms of palliative care consultation and patient outcomes (14-16). We need to understand how these disparities evolve in the surgical setting.

Being a narrative review, this paper is subject to the limitations that are common among narrative reviews, including the possibility of missed publications and the omission of several “trigger” tool articles that do not focus on patient-oriented outcomes but can potentially offer additional insight. Patients with ear, nose and throat

disease, urological diseases, left ventricular assist devices, cardiothoracic disease, and pediatric patients with heart failure have been excluded as well, as the review focuses on general surgery patients, however the experiences in these patients could likewise contribute valuable information. The review is not completely comprehensive, as many data from internal medicine populations may be relevant in the surgical populations as well. The inclusion of expert guidance and perspective pieces make the review more comprehensive but could also introduce bias. The inclusion of conference abstracts might lead to missing or incomplete information. The review does not assess study quality, which can also lead to biases. In spite of these limitations, Kopecky *et al.* provide a very comprehensive, well-structured review of the current literature on the topic of surgical palliative care and emphasize the gaps that need to be filled.

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