PALLIATIVE CARE ECHO
June 28, 2021
VCU Health

Palliative Care vs. The Surgeon

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Palliative Medicine Fellow

Virginia Tech Carilion School of Medicine

Objectives

- Understand the evolution of the relationship between surgeons and palliative medicine
- Discuss the impact the modern relationship can have on patient outcomes (*open discussion, prepare to share experiences)
- Outline opportunities and barriers for productive integration of the two specialties

Surgery:
A struggle against suffering

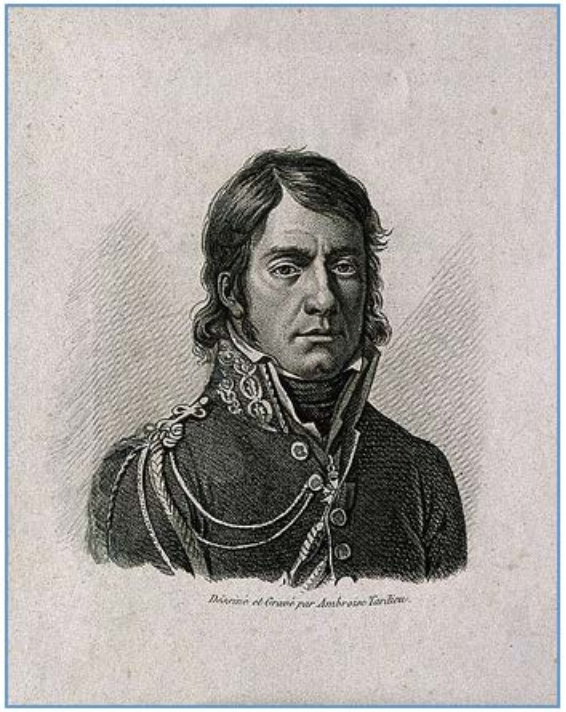
- Mortality >> survival
- Physical and mental torture, infection, pain
- Inevitable complications

Prior to 1800

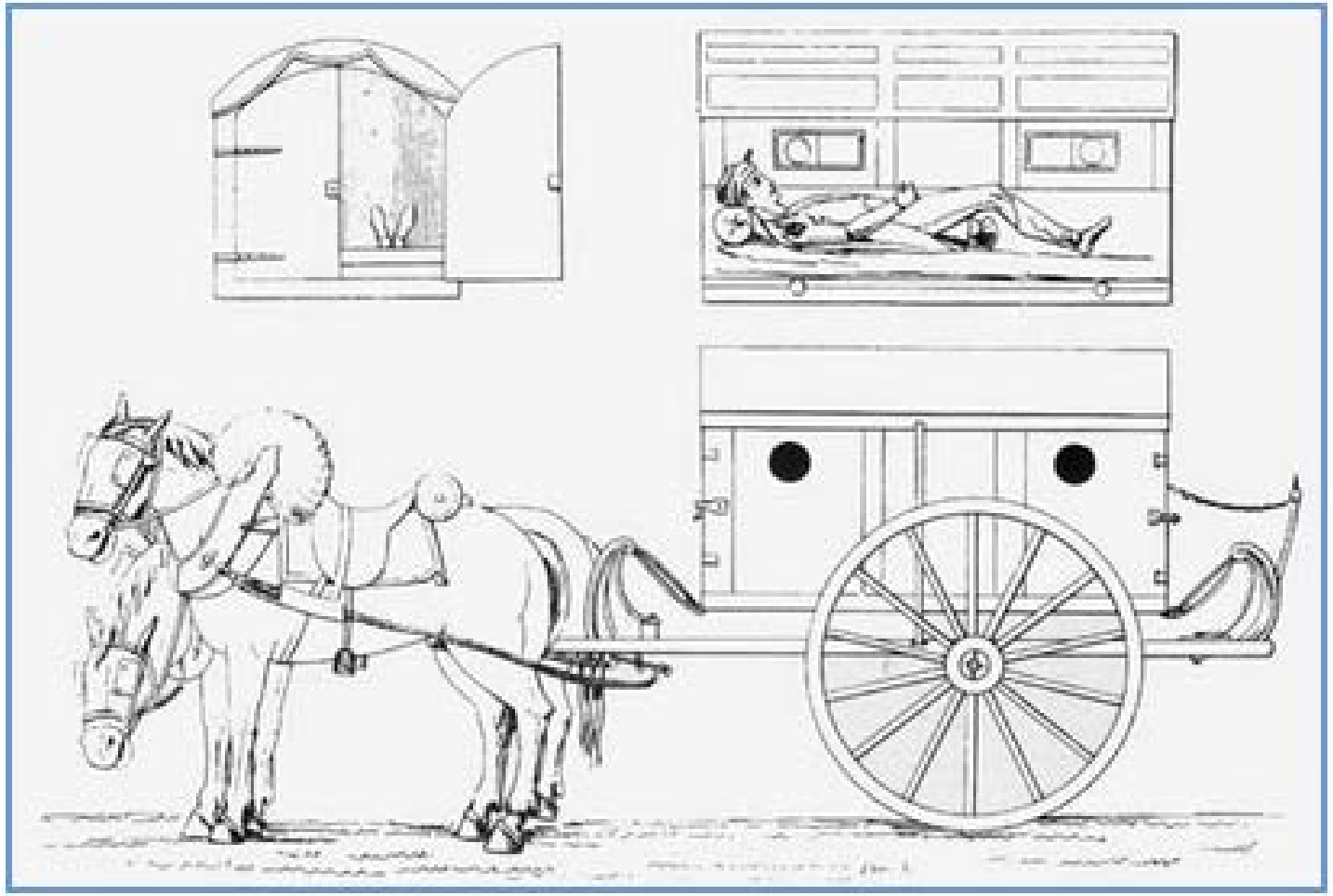
The first operations were palliative

- Trepanation
- Blood-letting
- Suturing wounds
- Drainage
- Bone setting
- Tooth extractions
- Debridement
- Amputation
- Bone setting
- Tooth extractions

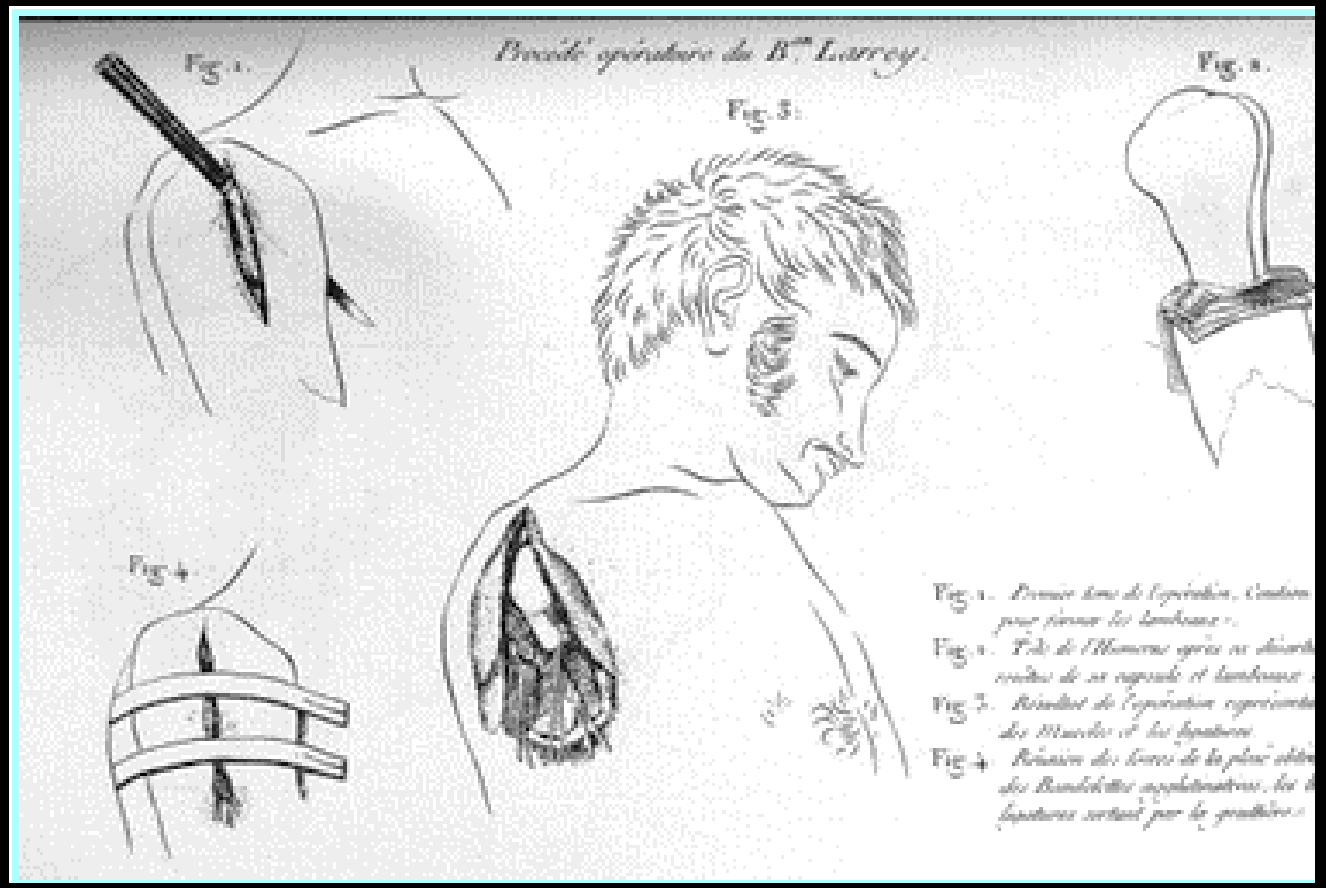
Baron Dominique-Jean Larrey: Humanitarian impulse to salvage the injured, conserve morale



Field ambulance
Forward medical teams
Triage



AMPUTATION



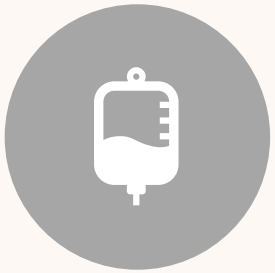
Wounds, infection, disability, gangrene, possible death

vs.

Certain death

Innovations in Medicine:
Surgeons alleviate suffering without operating

ANESTHESIA

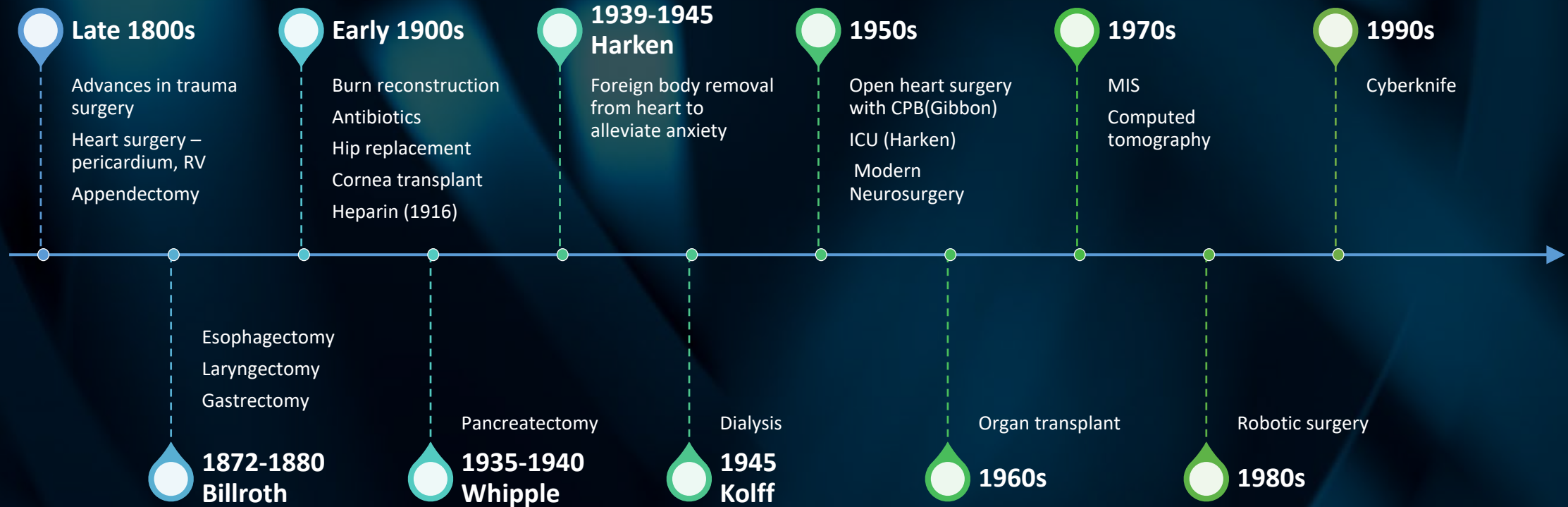


BLOOD TRANSFUSIONS

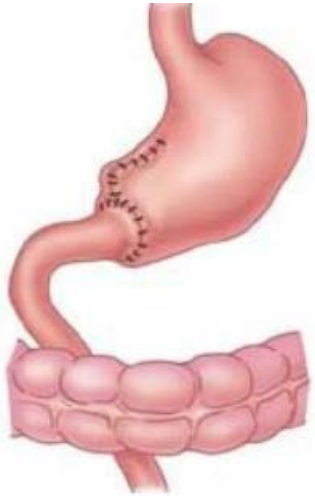
X-RAY

DISINFECTION

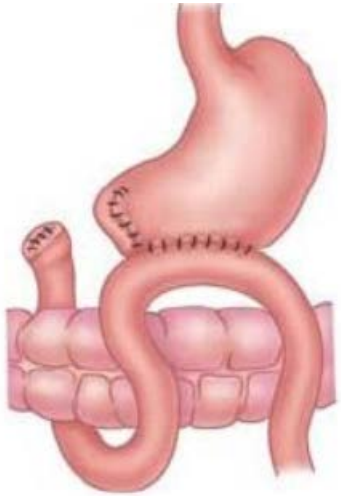
Innovation: a double-edged sword that led to a shift in indications for surgery



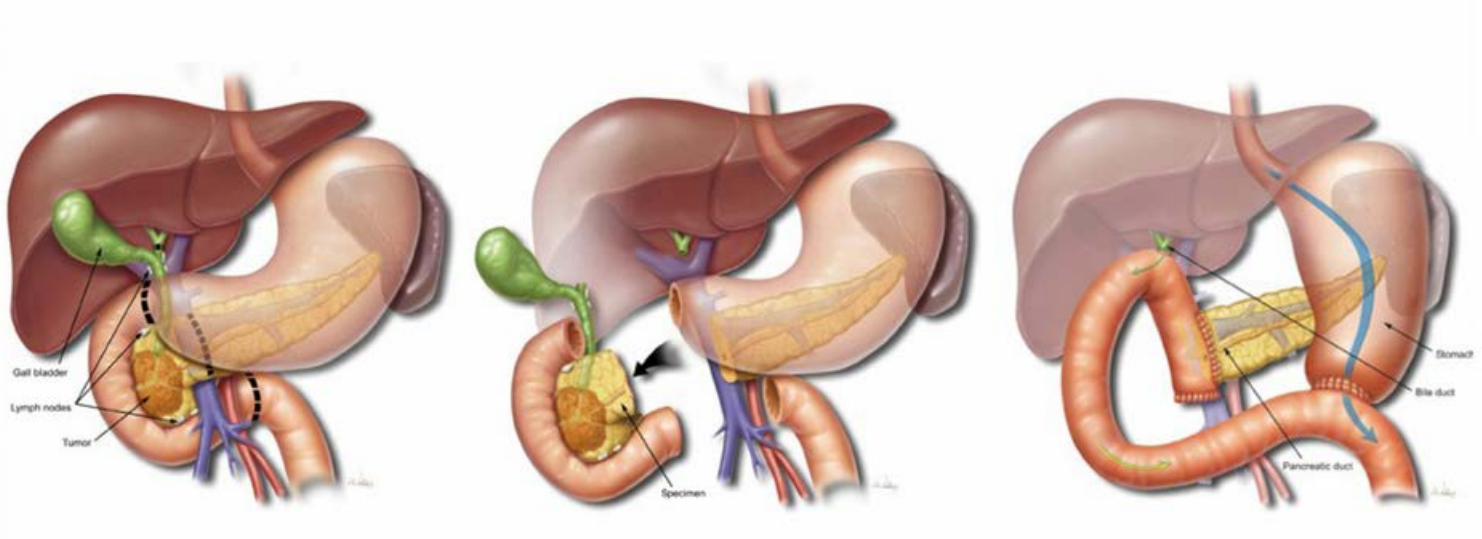
Billroth and Whipple



Billroth I

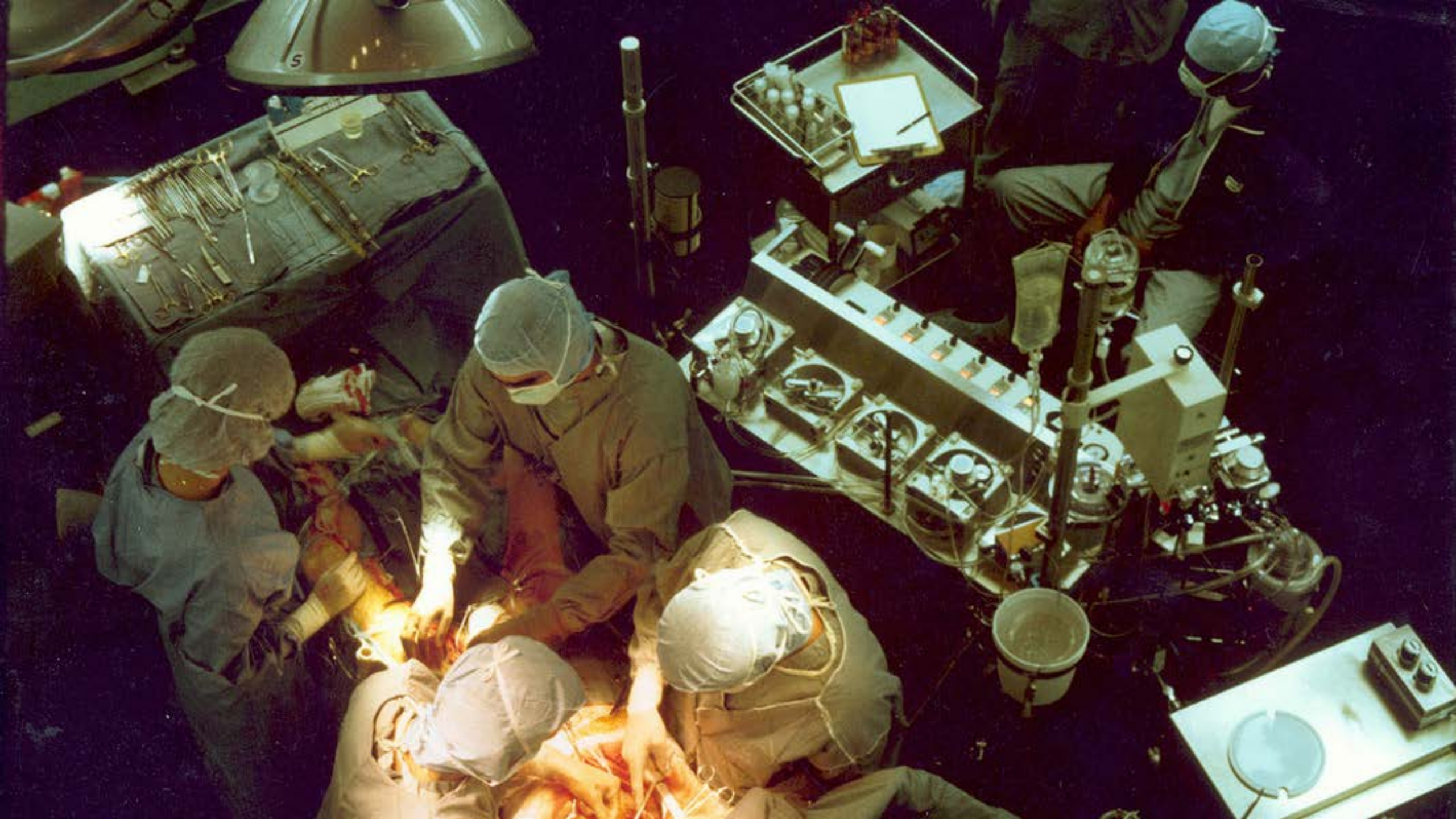


Billroth II

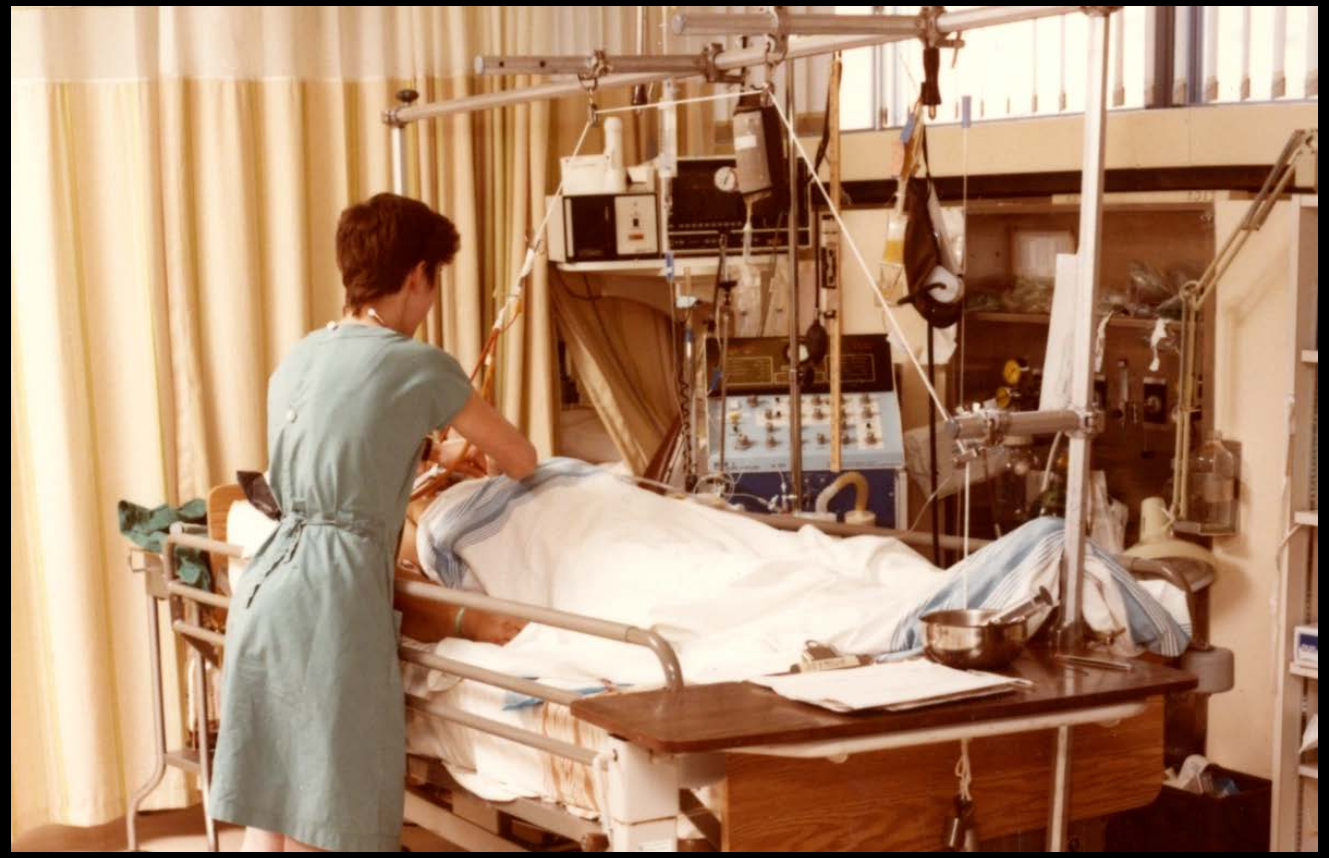


A shift in surgery from palliative to curative

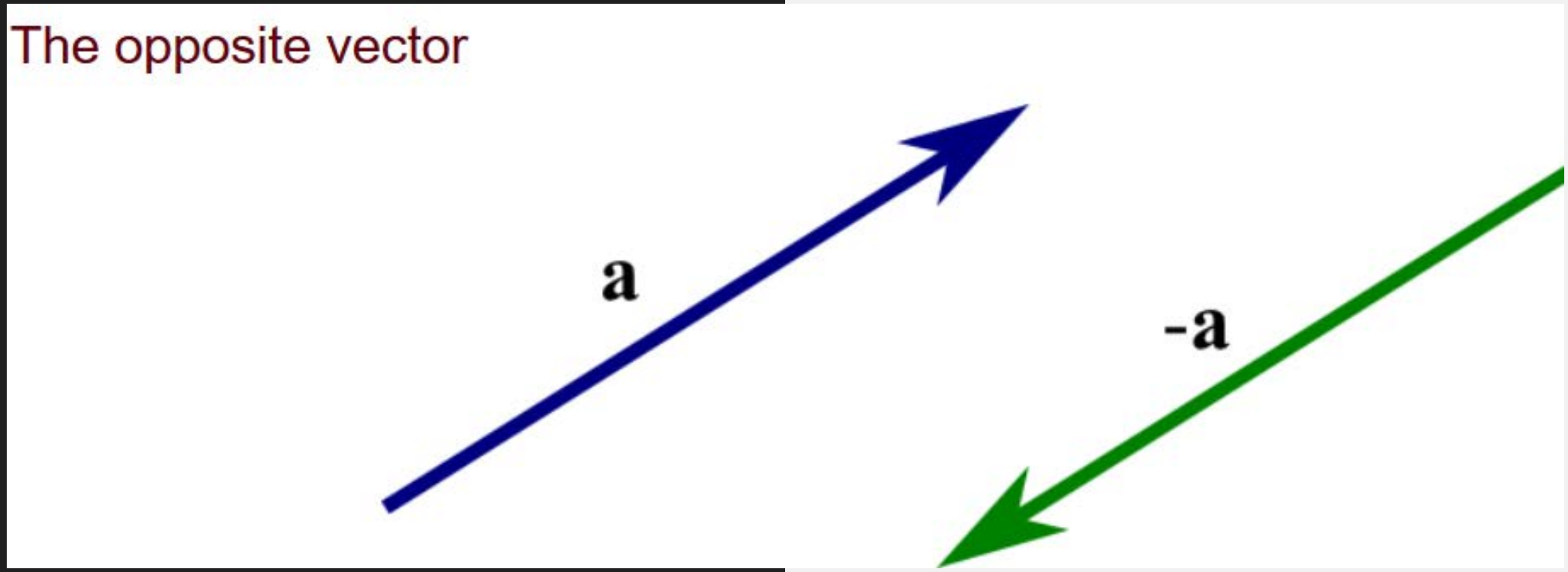
- Direct operation on the heart
  - 134 FB removal operations, 0 mortality
  - Primary, palliative indication
    - Alleviate debilitating anxiety
- Elective cardiac surgery
  - Mitral commissurotomy, valve replacement
- ICU



ICU



- 1960: more feared than cardiac surgery itself.
  - Dehumanization
  - Sensory deprivation
  - Sensory overload
  - Pain
- Harken: “Well first you have to cure the disease and then you have to cure the cure!”



Relief of suffering

$\overline{\text{}}$*Saving life*

Fix-it Mindset

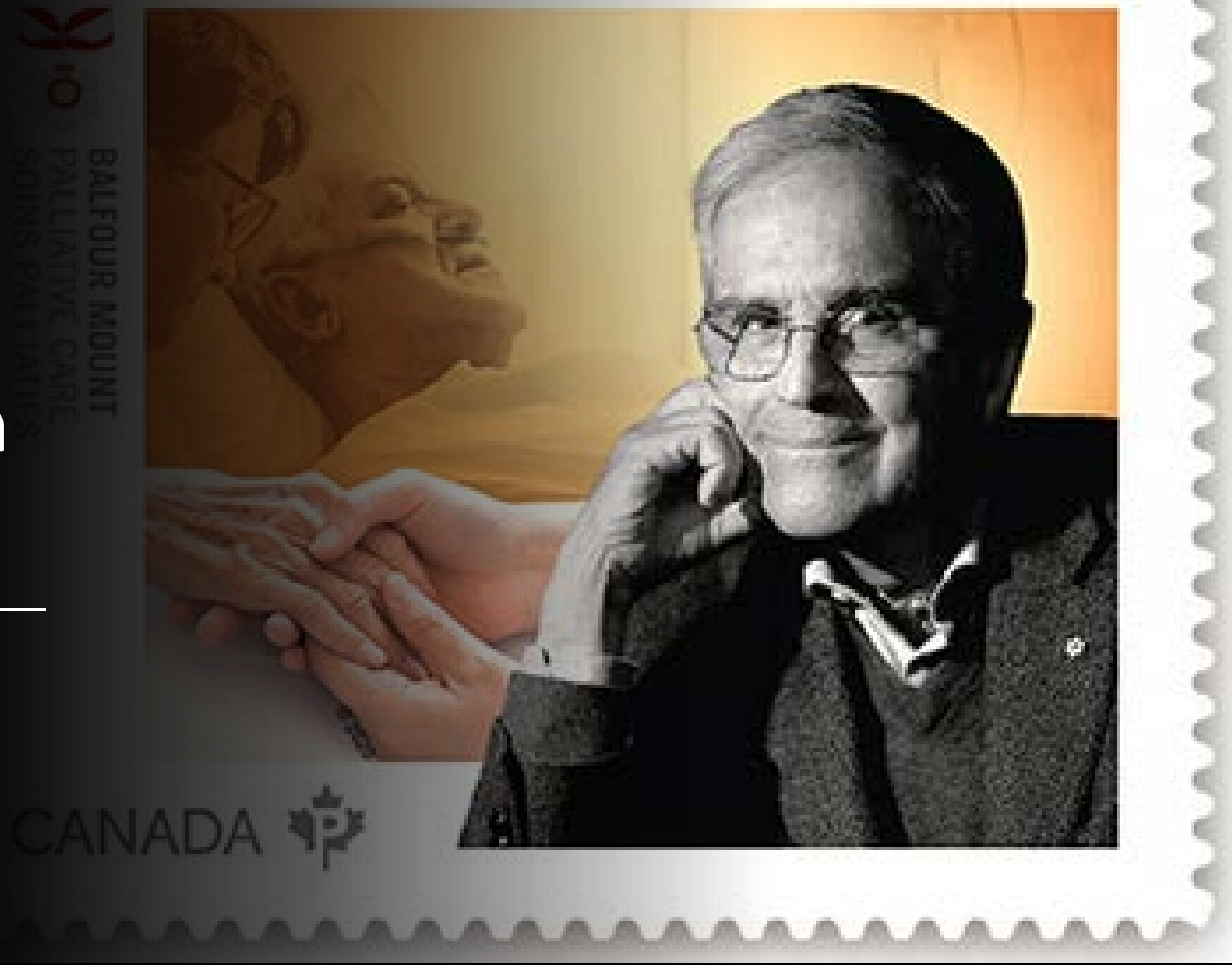
A chance to cut is a chance to cure

- Elective Surgery
- Neurosurgery
- Transplant Surgery
- Surgical Oncology
- Minimally invasive surgery

New forms of suffering

An era of unwilling existence

Balfour Mount: Coined the term “palliative care”



Report from the Field

Approaching Death: Improving Care at the End of Life–A Report of the Institute of Medicine

5. Palliative care should become, if not a medical specialty, at least a defined area of expertise, education, and research. The objective is to create a cadre of palliative care experts to (a) provide expert clinical consultation and role models for colleagues, students, and other members of the healthcare team; (b) supply educational leadership; and (c) organize and conduct research.

HSR: Health Services Research 33:1 (April 1998)

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Inspiring Quality: Highest Standards, Better Outcomes

1998 – A Shift in Mindset

ACS Statement of Principles Guiding Care at the **End of Life**

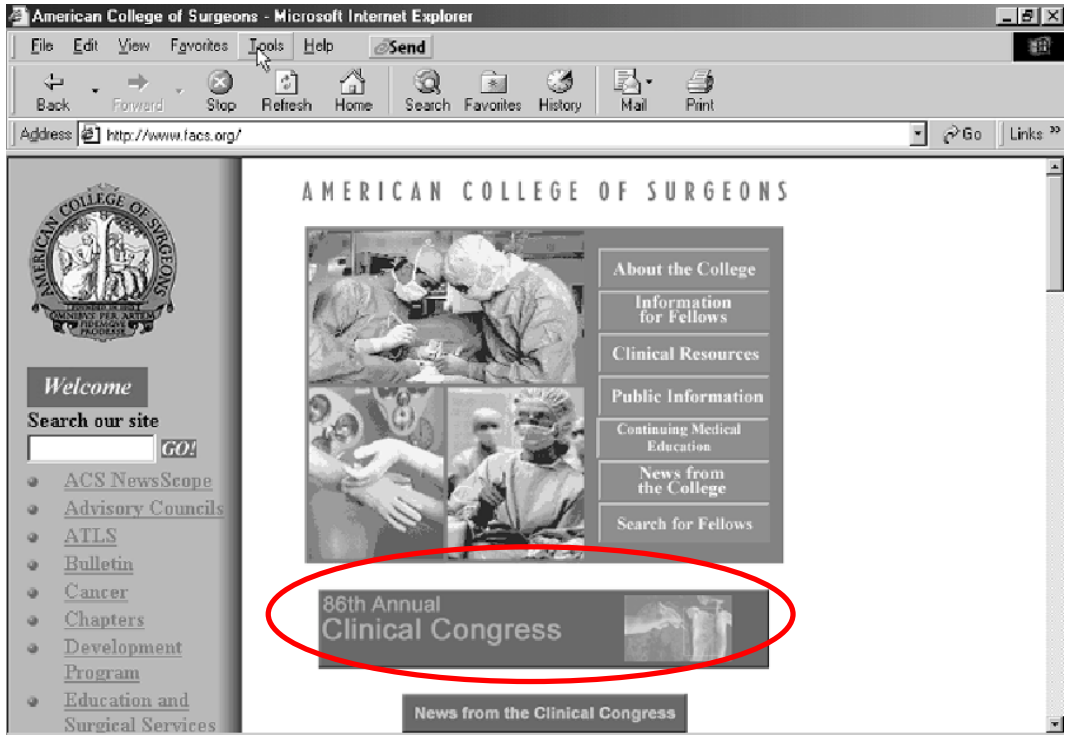
Respect patient's wishes, right to refuse treatment

Provide access to therapies that may improve QoL

Provide access to palliative care and hospice care.

Physician's responsibility to forego treatments that are futile.

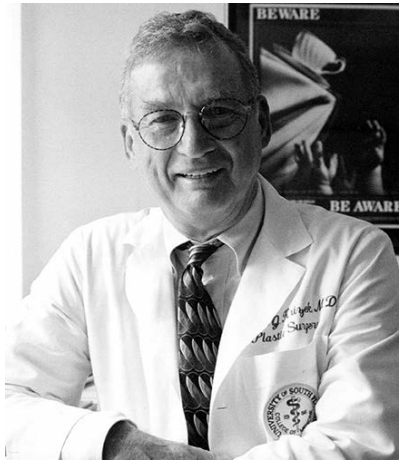
Palliative Care by the Surgeon: Patient Selection and Management



2000 Chicago, IL

C. James Carrico
Surgeon

Thomas Krizek
Surgeon



Kathleen Foley
Neurologist

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100+years

Statement of Principles of Palliative Care

Bulletin of the American College of Surgeons Vol.90, No. 8, August 2005

"…extending palliative care to a broad range of patients receiving surgical care."

"The control of suffering is of equal importance to the cure of disease."

"The surgeon is positioned to take a leadership role in advocating for palliative care."

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Statement of Principles of Palliative Care

Bulletin of the American College of Surgeons Vol.90, No. 8, August 2005

- Identify primary goals of care, address how surgeon can help achieve them

- Provide therapeutic support on a spectrum from life-prolonging treatments to hospice care…

…when they can improve QoL

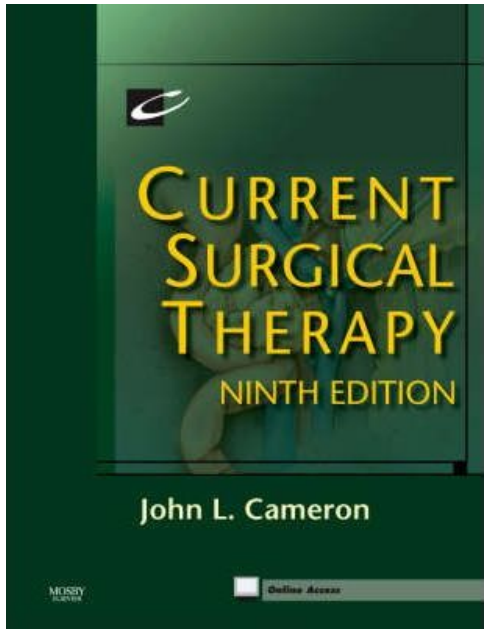
Olga Jonasson

- Transplant Surgeon
- 1st Woman named Chair of Surgery
- ACS Director of Education and Surgical Services
  - Founder of NSQIP
  - Landmark studies on inguinal hernia
  - **Surgeons Palliative Care Workgroup**

John L. Cameron

- Chief of Surgery Johns Hopkins
- Whipple mortality 30% to < 2%
- President of the ACS 2008
- Editor of first major surgical text to recognize Surgical Palliative Care as a distinct specialty

"…the treatment of suffering and the promotion of quality of life for seriously or terminally ill patients under surgical care."



2008

ABS CERTIFICATION		
1937	General Surgery	30,077
1974	Pediatric Surgery	1,079
1982	Vascular Surgery	3,503
1986	Surgical Critical Care	3,588
1989	Hand Surgery	188
2008	Surgical Palliative Care (HPM)	75
2015	Complex General Surg Onc	307

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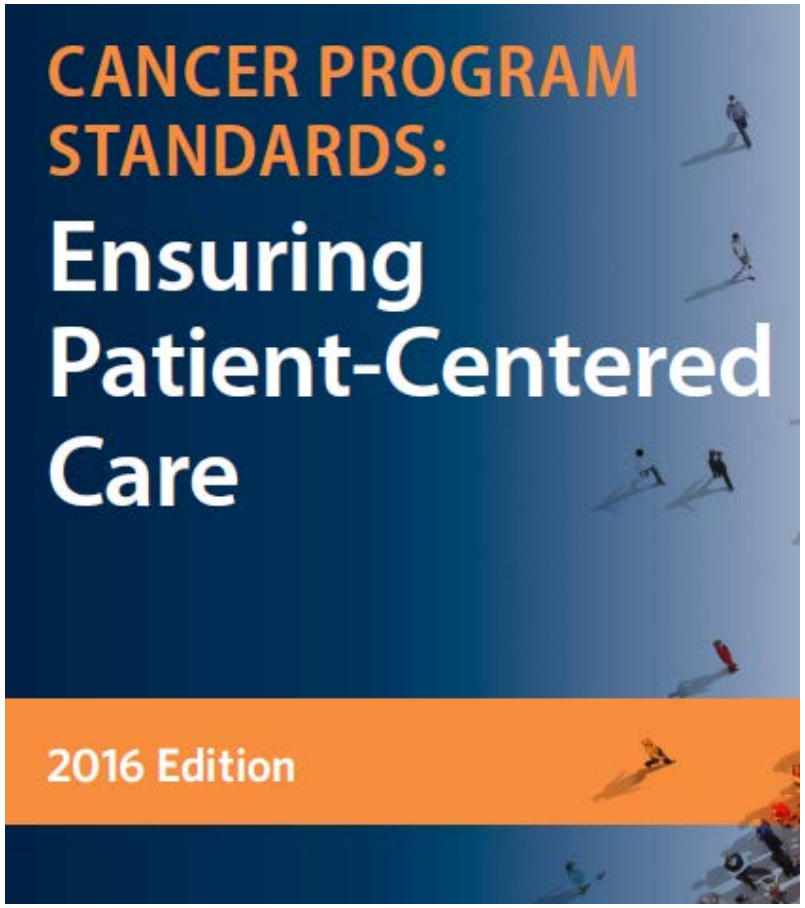

STANDARD 2.4
Palliative Care Services

- Palliative care is not hospice care
- Essential component of cancer care, beginning at diagnosis
- Palliative services are provided by a multidisciplinary team that includes surgeons

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Inspiring Quality: Highest Standards, Better Outcomes

THE COMMITTEE ON TRAUMA

2017

ACS TQIP PALLIATIVE CARE BEST PRACTICES GUIDELINES

VTC | Virginia Tech Carilion School of Medicine

CARILION CLINIC

Key Messages

- Best practice palliative care is delivered *in parallel* with life-sustaining trauma care, throughout the continuum from injury through recovery.
- The unit of care is the patient and family.
- Core trauma palliative care can and should be provided by trauma center teams even if palliative care consultation is not available.
- Optimal palliative care requires an interdisciplinary team of physicians, nurses, and psychosocial and rehabilitation providers.
- Optimal care requires trauma physicians and nurses to have basic competencies in primary palliative care, pain and symptom management, and end-of-life care.

Accreditation Council for Graduate Medical Education

Palliative Care Training Requirements for Internal Medicine Residents:

- “Residents should have an opportunity to experience palliative care without required exposure”

Accreditation Council for Graduate Medical Education

Palliative Care Training Requirements for General Surgery Residents:

N/A*

Current Relationship between Surgery and Palliative Care

- General awareness
  - End of life care
  - Trauma and Surgical Oncology
- Small group of advocates with a line item on the national agenda
- Individuals within specific institutions
- Mandated involvement for COE

Current Relationship between Surgery and Palliative Care

Variable

- Collaborative
- Limited understanding of field
- Late consultation
  - 30 days*
  - End of life
- The soloist - denies involvement

- Middle-aged adult (40s)
- **ECMO for Covid, graduated to conventional ventilator**
- **Remained in ICU**
  - Renal failure, respiratory failure, adrenal insufficiency, metabolic encephalopathy
- **>60 days later, acute septic shock**
  - Ischemic gut due to embolic event
  - Intestinal surgery resulted in malabsorption, anticipated lifelong TPN
- **Complications, inability to heal, ventilator, pressors, steroids, RRT**
  - Late anastomotic leaks (3 weeks!) with poor prognosis for survival
  - **General surgeonS recommended palliation**, covering CT surgeon agreed
  - Palliative Medicine consulted
  - Plans for transition to comfort care
- **Primary CT surgeon returned; goal changed to survival with DNR**
  - Additional surgeries
  - Short term improvement – opportunity to speak with wife(!)
  - Subsequent failure
  - Transition to comfort, death with withdrawal of LST (No Pall Med team)

Unwanted
Rejected
Disrespected
Angry for the patient
☹

Your turn.

What are your stories?

What has been frustrating about working with surgeons and surgical patients?

How have the negative interactions impacted patients' outcomes?

Barriers

- Education
- Availability
- RESOURCES
- Knowledge gaps and language barriers between specialties
- Second guessing
- Prognostication
- Choice between surgery or palliation = life or death


Death =
FAILURE

Opportunities and Progress

- Elective surgery space
- Consult triggers
- Priority education for surgical trainees
- Diversity within Palliative Medicine teams
- Institutional surgeon advocate
- Small body of evidence
- Strong leadership

General Palliative Care

"Core competencies for all surgeons, inherent to providing good surgical care":

- Symptom management
- Communication
- Complex decision-making

Geoffrey Dunn, MD, FACS

Subspecialty Training

- Integrate palliative medicine with surgical care
- Specialize in procedures intended to improve QoL or alleviate symptoms caused by advanced disease

Bridget Fahy, MD, FACS

Surgical Palliative Care

- Dichotomous model most common
- Reunification of improved survival *and* QoL outcomes
- Concurrent palliative care improves QoL, caregiver burden, survival
- Symptom management from diagnosis to *survivorship*

Core Principles of Surgical Palliative Care

Symptom relief and QoL through *continuum* of illness or injury

Delivered in parallel to life-prolonging therapies

Decision for surgery: ability to meet patient's goal > disease-modifying ability

Prognosis includes QoL outcomes

Shared decision-making: prognosis, uncertainty, GoC

EoL care to include palliative operations

Dr. Karen Brasel:
Mandates Palliative Care Training for General Surgery Residents

Dr. Gretchen Schwarze

- Vascular surgeon
- National leader in Palliative Care
- Develops and validates tools to facilitate shared decision-making
- Defined knowledge gaps in Surgical Palliative Care
- Published research priorities for Surgical Palliative Care

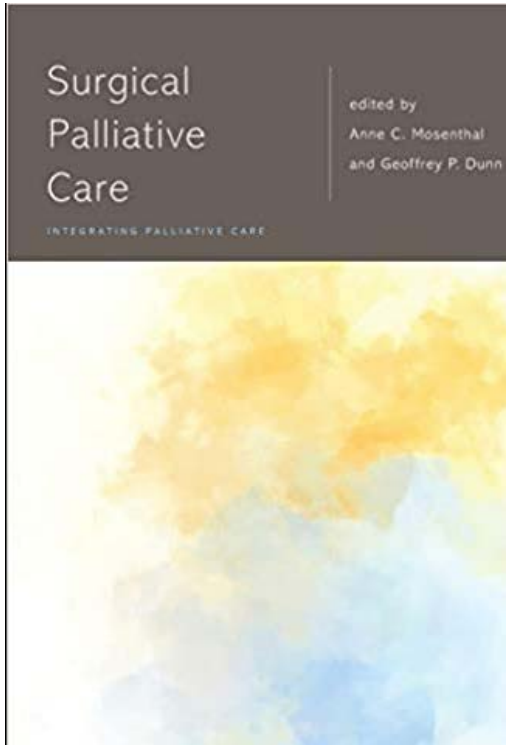
Resources

- Surgical Palliative Care Podcast
- Twitter @Surgpallcare
- AAHPM Communities
- ACS Clinical Congress
- Resident Guidebook

https://www.facs.org/~/media/files/education/palliativecare/surgicalpalliativecareresidents.ashx

https://thesurgicalpalliativecarepodcast.buzzsprout.com/

Surgical Palliative Care Textbook



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