Patients' Goals and Preferences for Medical Treatment During Decisions About High-Risk Emergency Surgery

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Scholarly Report Title: Patients' Goals and Preferences for Medical Treatment during Decisions about High-Risk Emergency Surgery

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Abstract:

Title: Recommendations for Best Communication Practices to Facilitate Goal-concordant Care for Seriously Ill Older Patients With Emergency Surgical Conditions.

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Objective: To address the need for improved communication practices to facilitate goal-concordant care in seriously ill, older patients with surgical emergencies.

Summary Background Data: Improved communication is increasingly recognized as a central element in providing goal-concordant care and reducing health care utilization and costs among seriously ill older patients. Given high rates of surgery in the last weeks of life, high risk of poor outcomes after emergency operations in these patients, and barriers to quality communication in the acute setting, we sought to create a framework to support surgeons in communicating with seriously ill, older patients with surgical emergencies.

Methods: An interdisciplinary panel of 23 national leaders was convened for a 1-day conference at Harvard medical school to provide input on concept, content, format, and usability of a communication framework. A prototype framework was created.

Results: Participants supported the concept of a structured approach to communication in these scenarios, and delineated 9 key elements of a framework: (1) formulating prognosis, (2) creating a personal connection, (3) disclosing information regarding the acute problem in the context of the underlying illness, (4) establishing a shared understanding of the patient's condition, (5) allowing silence and dealing with emotion, (6) describing surgical and palliative treatment options, (7) eliciting patient's goals and priorities, (8) making a treatment recommendation, and (9) affirming ongoing support for the patient and family.

Conclusions: Communication with seriously ill patients in the acute setting is difficult. The proposed communication framework may assist surgeons in delivering goal-concordant care for high-risk patients.

Research Context: In the practice of modern medicine, shared decision-making is the preferred approach for preference-sensitive medical decisions where the risks and benefits of treatment depend on patients' goals and values around medical interventions (1). In the case of elderly patients facing decisions about high-risk emergency surgery, understanding the patient's goals for medical treatment with regard to expected quality of life and functional status is crucial to treating patients who may require prolonged hospitalization, or life-sustaining therapy for recovery from surgery or surgical complications. Currently, surgeons do not have a validated, structured approach to elicit patients' goals and values for medical treatment in the perioperative period or to understand a patient's tolerance for the burdens of treatment, with respect to prolonging life, achieving cure, maintaining function and quality of life, or achieving life goals (2).

An aging population, combined with the growing burden of chronic disease, means that surgeons increasingly face decisions about offering emergency surgery to elderly patients with serious underlying illness. Although emergency surgery in these patients may prolong life, these operations are associated with high rates of postoperative mortality and morbidity that can threaten quality of life and patient function. Among patients admitted to surgical intensive care units (SICUs), survival is dependent both on age and underlying disease process (3). The mortality rate among patients in SICUs is significant. Patients who are admitted to the SICU for at least 7 days have been shown to have a 40% mortality in the SICU and a 50% 1-year mortality (4). Furthermore, there was an increase from 2000 to 2009 in ICU admissions in the last 30 days of life, delayed referral to hospice, and burdensome transitions between healthcare facilities near the time of death (5). These data suggest a shift toward more aggressive care of elderly patients at the end of life. Importantly, seriously ill patients who die in the hospital or ICU have worse psychosocial wellbeing and increased physical discomfort in the last week of life (6,7), and their family members suffer from high rates of complicated grief (8). Alternatively, patients who have the opportunity to discuss their end-of-life preferences with a physician and receive care concordant with their goals report less physical discomfort at the end of life (9). Given the potential for death and disability after surgery, surgeons should understand patients' goals for medical treatment and their tolerance for the treatment burdens expected in perioperative care.

Conversations between surgeons and patients should address patient goals and values for medical treatment and establish treatment preferences based on these goals. Yet, even when surgeons do speak to patients pre-operatively about risks and potential outcomes, these

conversations are not clearly focused on understanding patient goals for medical treatment (10,11). Surgeons encounter a particular set of challenges associated with eliciting patient goals. Norms within surgical culture dictate individual responsibility of surgeons for patients' outcomes such that surgeons find it particularly difficult to recognize poor outcomes (10); performance measures typically focus on mortality rather than function or quality of life (12). Surgeons feel a responsibility to maintain life support post-surgically (10) and feel conflicted about operating on patients who have advance directives (13). Furthermore, evidence suggests that surgeons, like other physicians, are generally poor prognosticators (14), poor at communicating prognosis to patients and families (15), and delay or fail to have conversations about end-of-life care (16). Complicating matters is the reality that patients in the SICU post-operatively are frequently unable to communicate, making it difficult to elicit treatment preferences or clarify preferences with surrogate decision makers (17).

Furthermore, surgeons face several unique challenges in the emergency surgical setting as opposed to the elective surgical setting. Emergency surgeries are inherently distressing for patients and their families. Surgeons often meet patients for the first time immediately before the surgery, making it difficult to establish a trusting relationship. Furthermore, patients may be in extremis and unable to speak for themselves, leaving decisions to surrogates who may be unprepared for their role, and are unfamiliar with the patient's wishes (14). As a result, it is difficult to clearly align surgeon and patient goals in the emergency surgical setting. We believe that improved pre-operative conversations between patients and surgeons can help define a good outcome from the patient's perspective, and inform how to direct treatment to achieve this outcome, or redirect treatment if this outcome is no longer achievable.

Studies to date have described pre-operative conversations between surgeons and patients in the elective surgical setting (10,11). To our knowledge, our work is the first to address the relationship between surgeon-patient communication and goal-concordant care in the emergency surgical setting.

Personal Contribution to Project:

I helped to convene a national advisory panel of interdisciplinary leaders that resulted in a publication in Annals of Surgery. The publication proposed a communication framework to assist surgeons in delivering goal-concordant care for high-risk patients. I wrote, with input from co-authors, the first four sections of the paper: (1) Purpose of the Advisory Panel, (2) Context,

(3) Barriers to Shared Decision Making and Communication in Emergency Situations, and (4) Goals of a Communication Framework. I also conducted qualitative interviews with emergency surgeons about pre-operative conversations with patients that helped to inform this advisory panel and will be published in future work.

Citation:

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