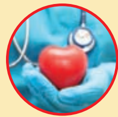

Palliative Care: The Unexplored Frontier of Anesthesiology

Palliative Care Interventions in Periprocedural Care

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The specialty of palliative care aims to support patients with serious illness in decision-making and symptom management. Palliative care expertise in these areas has been used to improve care processes in a number of settings, such as outpatient oncology clinics, intensive care units, and emergency rooms. In medical oncology, early palliative care involvement has been shown to improve symptom management and quality of life, reduce costs, and increase goal-concordant care. Palliative care integration into a preexisting care process often takes one of two pathways. In some instances, palliative care specialist clinicians are invited into and embedded within the care process. In other instances, palliative care specialists train clinicians already involved in the care process in the primary skills and knowledge of palliative care.

Compared to medical oncology, palliative care has been slow to be fully embraced and integrated into periprocedural care processes, such as surgical oncology. One possible reason is that the goals of palliative care and the periprocedural period appear to be at odds. The two aims of palliative care – decision-making and symptom management – appear to have already been addressed by the very decision to move forward with the procedure: the decision was made when the procedure was scheduled. The goal of the procedure itself is clear and aimed to alleviate symptoms or possibly to cure. As a result, where is the need for palliative care in periprocedural care processes?

Two recent studies looked at the benefits of palliative care for surgical oncology patients. In 2023, Shinall et al. published the first single-center randomized clinical trial of specialist palliative care intervention in the periprocedural period for patients undergoing surgery for abdominal malignancies with curative intent. The specialist palliative care intervention included preoperative consultation, postoperative inpatient visits, follow-up outpatient palliative care visits, and inpatient palliative care visits during any readmission. The primary outcome was physical and functional quality of life at 90 days. Secondary outcomes included overall quality of life and days alive at 90 days, along with overall survival to one year. The study showed no statistically significant differences between usual care and the specialist palliative care intervention for the primary or secondary outcomes (*JAMA Surg* 2023;158:747-55).

Aslakson et al., in 2023, published the first multicenter randomized clinical trial of specialist palliative care intervention in the periprocedural period for patients undergoing surgery for upper GI cancer with curative intent. The specialist palliative care intervention included preoperative consultation and postoperative outpatient follow-up visits at one week, one month, two months, and three months after surgery. The primary outcome was health-related quality of life at three months after surgery. The study found no difference in primary outcome between the intervention group and the control group. Of note, the study also found no measurable harm from the palliative care intervention in the control group of patients or in the group of participating surgeons (*JAMA Netw Open* 2023;6:e2314660).

Palliative care interventions around other interventions aimed at cures – like bone marrow transplant – have been shown to improve patient well-being (*Blood* 2023;142:913). The randomized controlled trials described above may have applied their palliative care intervention too broadly or too early in the patients' disease trajectory to show benefit. Still, a key takeaway from these studies is that periprocedural palliative care did not increase distress – in either patients or surgeons. This is an important finding, as clinicians can be reticent to have conversations about prognosis in serious illness (*Arch Intern Med* 1998;158:2389-95). While a broad periprocedural specialist palliative care intervention may not be effective, we advocate for building up primary palliative care skills among periprocedural clinicians, along with minimizing barriers to specialty palliative care consultation when needed. This would enable timely and effective palliative care to be provided for periprocedural patients who have specific palliative care needs.

One periprocedural need is clear communication and patient-centered decision-making within the periprocedural process. When patients need to have a conversation about prognosis, including what might happen as a result of a procedure, periprocedural clinicians benefit from having palliative care communication skills (or access to palliative care communication experts) to support the difficult work of having these conversations. Within the field of palliative care, talking about prognosis is often compared to performing a procedure, like a central line (*JAMA Intern Med* 2015;175:1268-9). Both a structured conversation and a line placement have defined steps that only make sense when completed in order. It's foolish to do the chlorhexidine wash *after* having inserted the needle. Familiarity with the basic steps of structured communication can support periprocedural clinicians as they guide conversations around prognosis.

Conversations that discuss prognosis and planning can be divided into four key steps (Figure). These steps are elaborated into more detailed structured communications tools used by many providers and institutions across the country such as SPIKES, the Serious Illness Conversation Guide, and REMAP (Reframe, Expect emotion, Map out patient goals, Align with goals, and Propose a plan) (*Oncologist* 2000;5:302-11; *Palliat Med Rep* 2020;1:135-42; *J Oncol Pract* 2017;13:e844-e850). Employing structured communication can support discussions of prognosis whenever risks and benefits need to be considered (or reconsidered) – during an initial consultation with a surgeon, a preoperative assessment/optimization clinic visit with an anesthesiologist or other periprocedural clinician, or even on the day of surgery. Conversations about prognosis often lead to strong emotions. Yet, clinicians can be reassured by remembering that such emotions confirm that the patient or family member is comprehending the news being delivered. Taking a moment to address emotion with empathy can make further cognitive recommendations and planning more effective (*JAMA* 1997;277:678-82).

For anesthesiologists, or clinicians other than the surgeon/proceduralist, discussing prognoses with patients can feel out of place in the preoperative period. Some might feel this must have already been addressed in the initial surgical consult. There are, however, multiple reasons why periprocedural clinicians should feel empowered to discuss a prognosis with patients and families in a structured way. On one hand, anesthesia itself can create physiologic stressors – such as the risk of postoperative cognitive deficit in patients with early-stage dementia. A periprocedural clinician other than the surgeon may be the best person to assess and convey this prognostic information. On the other hand, the periprocedural process itself may uncover new medical information that might warrant reconsideration of the prognosis. In this second case, structured communication tools can be used in discussions with both the patients and the interdisciplinary clinical team. Wish/worry/wonder is a structure for aligning values (wish), updating the medical context (worry), and making a recommendation (wonder). Wish/worry/wonder

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Agree on the medical context → Respond to emotion → Clarify values in the setting of that medical context → Make a recommendation

Figure: Structure of Serious Illness Conversation

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statements could be utilized to convey prognostic concern, not just to patients, but to the surgeon themselves:

*"I also **wish** for Ms. Y to have a successful cholecystectomy, while minimizing her risks from anesthesia. Unfortunately, her echo showed worsening pulmonary hypertension. I **worry** that a laparoscopic surgery would be higher risk for her than an open surgery. I **wonder** if the procedure could be done open, in order to decrease her OR time and avoid laparoscopic surgery. What do you think?"*

The primary tenet of palliative care is patient-focused support through excellence in symptom management and communication. The aim is for medical care to achieve a patient's goals while preserving what a patient values. For complex medical issues or psychosocial situations, specialty palliative care referral may be the best way to achieve this. For most situations, however, a clinician familiar with these tenets and tools can provide primary palliative care, such as when discussing a "prognosis" with patients, including what might happen as a result of a procedure. While becoming truly proficient in primary palliative care does require knowledge acquisition and skills practice, the work to acquire this proficiency can benefit periprocedural patients, their families, and the clinicians themselves. ■

Anesthesiologists' Moral Distress
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may feel obligated to proceed (*J Gen Intern Med* 2021;36:1890-7; *JAMA Surg* 2016;151:309-10).

Using perioperative goals-of-care discussions to reduce moral distress

Let's recall our hypothetical patient. For clinical situations like this one, a perioperative goals-of-care discussion may help limit moral distress for anesthesiologists. A patient's goals of care represent intentions of treatment during a particular episode of care. While our hypothetical patient most likely engaged in goals-of-care discussions throughout her cancer treatment, an additional discussion is needed in the preoperative setting because the patient's health status has changed, and a new treatment option – major surgery – has been introduced.

By eliciting the patient's goals within the context of the perioperative period, the anesthesiologist learns whether the patient's expectations align with realistic surgical outcomes. This information also clarifies whether the patient possesses the necessary information to make an autonomous decision about his/her medical care. Lastly, this conversation provides an opportunity for the anesthesiologist to discuss any ethical concerns with the patient.

Let's say our patient decides to pursue surgery with the goal of relieving pain. The anesthesiologist may have concerns about added pain in the immediate postoperative period from surgery, prolonged intubation, and reduced physical function due to immobility. Discussing the patient's goals and the anesthesiologist's concerns prior to surgery may decrease moral distress: At the end of the conversation, the anesthesiologist may come to feel as though they acted in concordance with, rather than in violation of, broadly accepted ethical principles.

Practical tips for perioperative goals-of-care discussions

Various frameworks for conducting goals-of-care discussions exist (asamonitor.pub/3zg3qJx; *J Oncol Pract* 2017;13:e844-e50). A key component of each involves the discussion leader expressing a desire to understand the patient's hopes for the future in the context of their illness. To gain this knowledge, anesthesiologists may use open-ended questions, such as asking how the patient envisions life following surgery. While answers will vary significantly, the anesthesiologist should evaluate whether the patient's expectations align with anticipated postoperative outcomes. If the anesthesiologist is uncertain of what expectations are reasonable, or if the patient's hopes for the future differ greatly from the likely outcomes, then the surgeon and possibly a palliative care specialist should be engaged for further conversation. Overall, increasing interdisciplinary discussions in complex clinical scenarios may alleviate moral distress for all involved parties (*JAMA Surg* 2016;151:309-10).

Systems-level interventions to prevent moral distress

While perioperative goals-of-care discussions can be carried out by individual anesthesiologists, systems-level interventions are required to prevent morally distressing situations from arising. While a full discussion of systems-level interventions is beyond the scope of this article, anesthesiologists should consider quality improvement efforts at their own institutions that identify and address the root causes of moral distress. Anesthesiologists can consider improving systems surrounding perioperative code status, completion of advance directive documents prior to planned major surgeries, and/or creation of preoperative optimization protocols for patients with serious illness (asamonitor.pub/4ggZHft). Forming a peer support program, providing access to individuals trained in psychological first aid, and/or implementing structured debriefs following unexpected outcomes provide outlets for anesthesiologists who may be suffering from moral distress (*Int J Environ Res Public Health* 2021;18:4594; *Cochrane Database Syst Rev* 2002;2:CD000560; *J Bioeth Inq* 2021;18:573-87).

Moral distress commonly occurs in anesthesiologists who care for seriously ill patients. Contributing factors include the feeling of providing care that may seem unwarranted, lack of support and respect from peers, patients, and hospital systems, and lack of power to decide if and when high-risk surgeries are offered. To mitigate this distress, anesthesiologists can improve their skills in conducting focused perioperative goals-of-care discussions. Such conversations provide anesthesiologists with insights into the patient's goals and expectations following surgery. If significant discrepancies between the patient's hopes and the likely realities are revealed, then more in-depth goals-of-care discussions with other stakeholders should be conducted. On top of these skills, anesthesiologists may also engage in systems-level quality improvement projects aimed at prevention of moral distress. Through partnership with our patients, surgeons, and other OR staff, we can create a healthier environment for all by limiting the frequency at which morally distressing situations occur and promoting strategies at both individual and systems levels for coping with them. ■

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