Mahidol University
Faculty of Medicine Ramathibodi Hospital

Communication Skills & Advance Care Planning

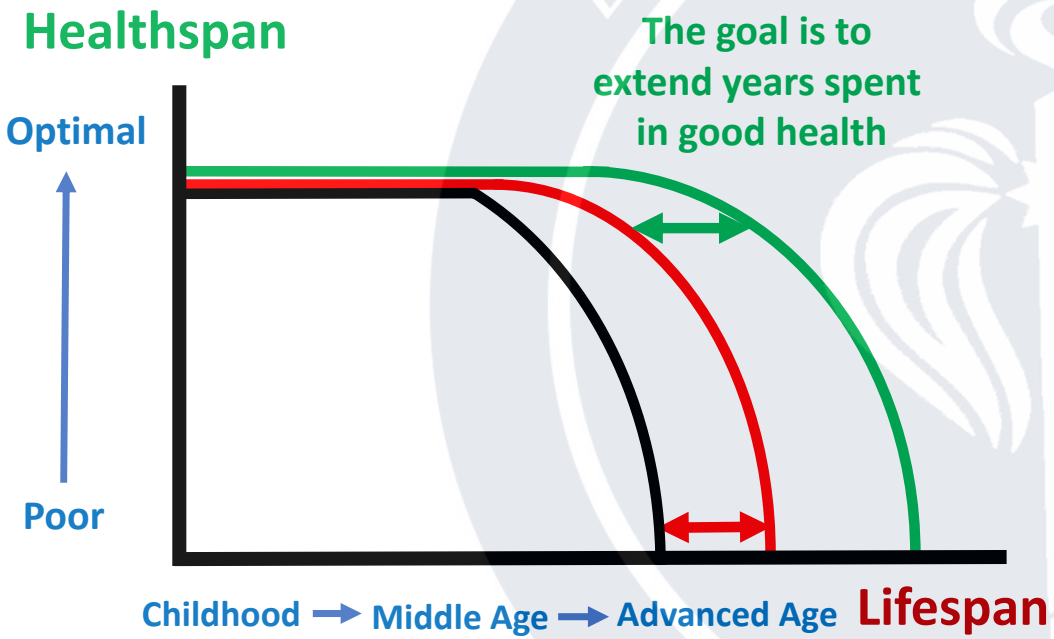
Jintana Assanasen, MD

Ramathibodi Palliative Care Center of Excellence

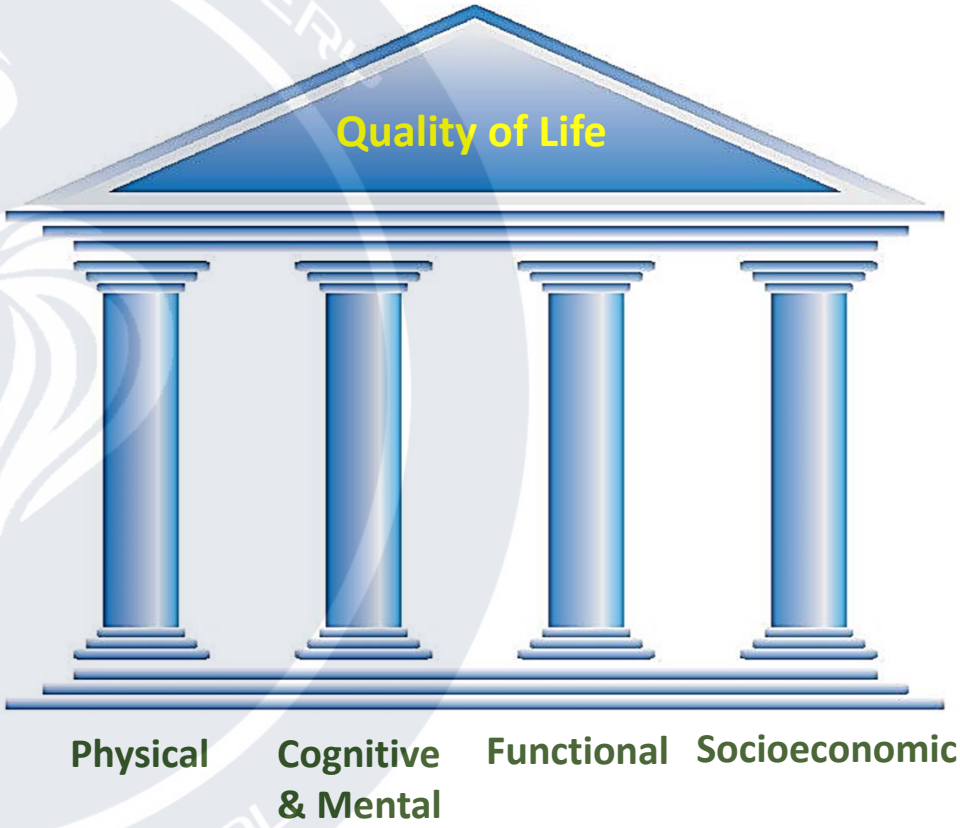
Faculty of Medicine Ramathibodi Hospital, Mahidol University

Bangkok, Thailand

Lifespan VS Healthspan

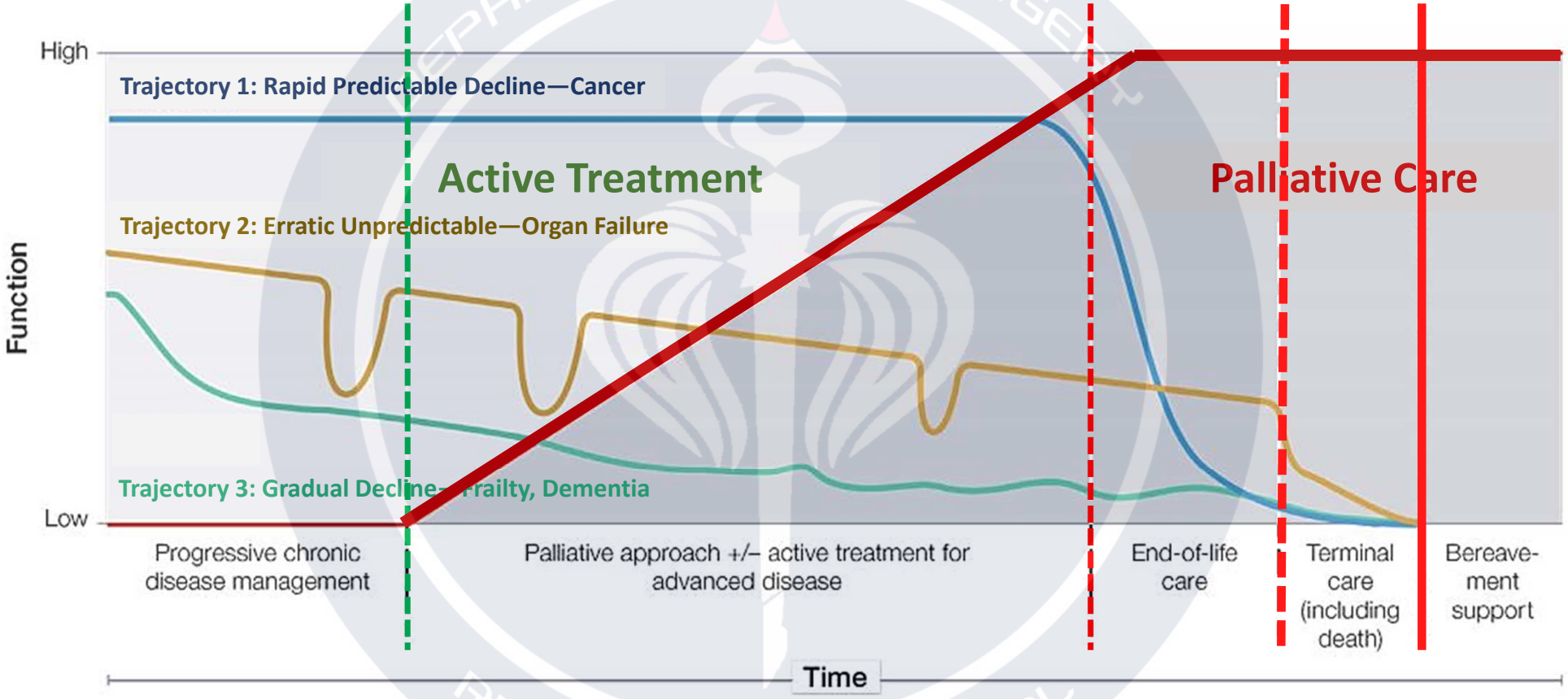


Comprehensive Assessment Domains



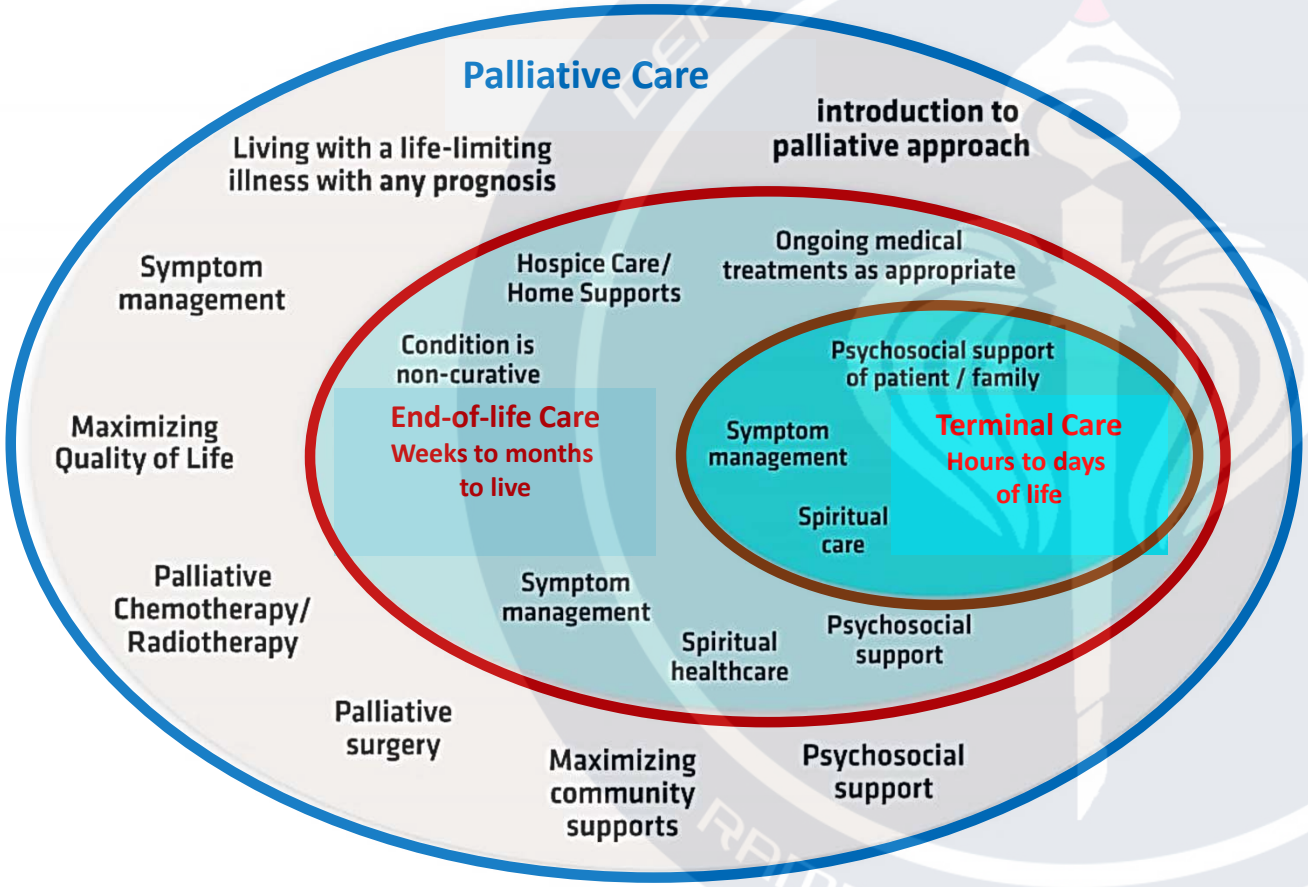
Comprehensive Geriatric Assessment - Geriatrics - MSD Manual Professional Edition (msdmanuals.com)

Illness Trajectory



https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care

The Phases and Layers of Palliative Care

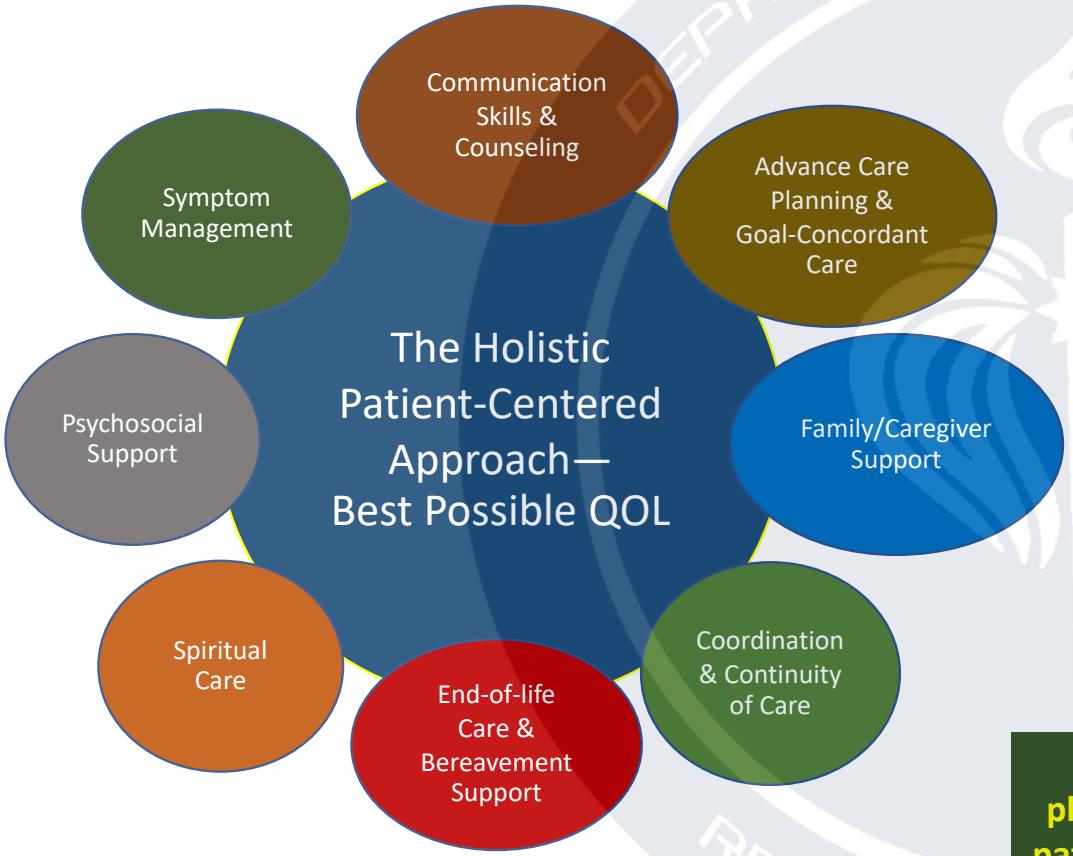


Definition of End-of-Life Care

- **Advanced, progressive, incurable conditions who are likely to die within the next 12 months**
- **Existing conditions if they are at risk of dying from a sudden acute crisis in their conditions**
- **General frailty and co-existing conditions that mean they are expected to die within 12 months**
- **Life threatening acute conditions caused by sudden catastrophic events**

https://link.springer.com/content/pdf/10.1007/s11864-022-00957-1.pdf?pdf=button%20sticky
https://www.goldstandardsframework.org.uk/PIG

Palliative Care Domains



Proactive Identification Guidance

Step 1: Identify
Patient who maybe in the last year of life and identify their needs-base stage

Step 2: Assess
Current and future,
clinical and personal needs, goals, values

Step 3: Plan
Living well and dying well

Earlier anticipation of likely needs and wishes, better advance care planning (ACP) discussions, proactive goal-concordant care tailored to patients' preferences, fewer crisis hospital admissions, better outcomes enabling patients to live and die where they choose at the end of life

https://www.goldstandardsframework.org.uk/PIG

Advance Care Planning (ACP)

- ACP is **an ongoing process** in which patients, their families or other decision-makers, and their health care providers **reflect on the patient's goals, values, and beliefs, discuss how they should inform current and future medical care, and ultimately use this information to accurately document the patient's future health care choices.**
- **Clinicians bear the responsibility of informing patients** about their prognosis, exploring treatment options, and helping **formulate preferences based upon a risk-benefit analysis and their values,** whenever circumstances allow.
- **The clinician must assess the patient's decision-making capacity** before concluding that the patient can or cannot speak for themselves.
- **Advance directives (ADs) are the documents a person completes while still in possession of decisional capacity to ensure their values** are reflected when considering how treatment decisions should be made **on their behalf in the event that they lose the capacity to make such decisions.**

https://www.uptodate.com/contents/advance-care-planning-and-advance-directives

Advance Care Planning (ACP)

- **The primary instruments that serve as AD documents are the Living Will (LW).**
- Given that preferences for life-sustaining therapy might change over time, **ADs should periodically be revisited, particularly at times when there is a change in the person's health or clinical decision-making is needed.**
- **A surrogate decision-maker (SDM) should be identified for all patients,** regardless of condition, because lost decisional capacity is common.
- **If a patient expresses wishes against resuscitation during an ACP discussion, it is important that they be followed by physician's orders regarding code status,** as ADs alone are insufficient to prevent a patient from being resuscitated.

https://www.uptodate.com/contents/advance-care-planning-and-advance-directives

Advance Care Planning (ACP)

ACP significantly improves multiple outcomes, particularly for patients with serious illness.
These include:

- higher rates of completion of ADs[1]
- reduced hospitalization at the end of life[2,3]
- fewer intensive and life-sustaining treatments at the end of life[2]
- increased utilization of palliative care and hospice services[2]
- increased likelihood that a patient will die in their preferred place[3]
- higher satisfaction with the quality of care due to improved communication between patient, family or surrogate decision-makers, and the patient's clinicians resulting in shared decision-making, and better preparation on what to expect during the dying process[1,2,3]
- lower stress, anxiety, and depression in surviving relatives of deceased persons[1,4]
- reduced cost of end-of-life care[2,5]

1. BMJ 2010; 340: 1345. 2. J Am Geriatr Soc 2007; 55:189. 3. JAMA 2000; 283: 1427. 4. JAMA 2008; 300: 1665. 5. Arch Intern Med 2009; 169: 480.

Decision Making Capacity

- Capacity refers to ***an individual's ability to understand and make specific decisions about their healthcare.*** It is ***a clinical assessment made by healthcare professionals*** to determine if ***a person has the requisite cognitive abilities to make informed decisions.***
- ***The patient is assumed to have decision-making capacity*** unless there is evidence to indicate otherwise.
- Competence or lack of competence ***can fluctuate over time and for different levels of decision making.***
- Competence is ***specific to the issues, actions or decisions at hand.***
- ***The patients*** should always ***be involved in decisions that concern them to the maximum extent possible***

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care

Decision Making Capacity

Assessing capacity is a clinical process conducted by healthcare professionals, typically involving the following components:

- ***Understanding***—assessing the patient's ability to ***understand relevant information related to his/her healthcare,*** including medical conditions, treatment options, risks, and benefits
- ***Appreciation***—evaluating the patient's ability to ***appreciate the implications and consequences of his/her healthcare decisions,*** considering his/her personal values, beliefs, and goals
- ***Reasoning***—determining if the patient can ***engage in logical reasoning and weigh the pros and cons of different treatment options***
- ***Communication***—assessing the patient's ability to ***communicate his/her decisions clearly, coherently and consistently***

If a person lacks capacity to make medical treatment decisions themselves, there are ***three ways*** in which decisions can be made by, or for them:

- ***An advance care directive made by the person before they lose capacity*** can provide directions about medical treatment
- ***A substitute decision maker*** can make the decision, based on what they believe the person would want and their best interests
- ***A tribunal or the courts*** can provide consent or make a treatment decision

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/part-a/palliative-care

Advance Care Planning (ACP)

- Understanding illness trajectories
- Conversations about the patient's goals, values, preferences
- Assessment of the patient's decision-making capacity
- Identifying the patient's SDM(s)
- Documentation of ACP and/or AD (where applicable)

Goals of Care (GOC)

- Assessment the patient's decision-making capacity
- Identifying the patient's SDM(s)
- Discussions about current medical conditions, diagnosis, prognosis, risks/benefits of treatment options, trade-offs, complications, burden and cost
- Clarification of previous ACP, current goals, values and preferences

Decisions

- Specific to the issues and decisions at hand
- Goal-concordant care plan
- Documentation of goals-of-care discussion, consent for treatments/interventions
- Assessment of the patient's responses to treatments/interventions
- Reevaluation of goals of care when appropriate

Communication in Palliative Care

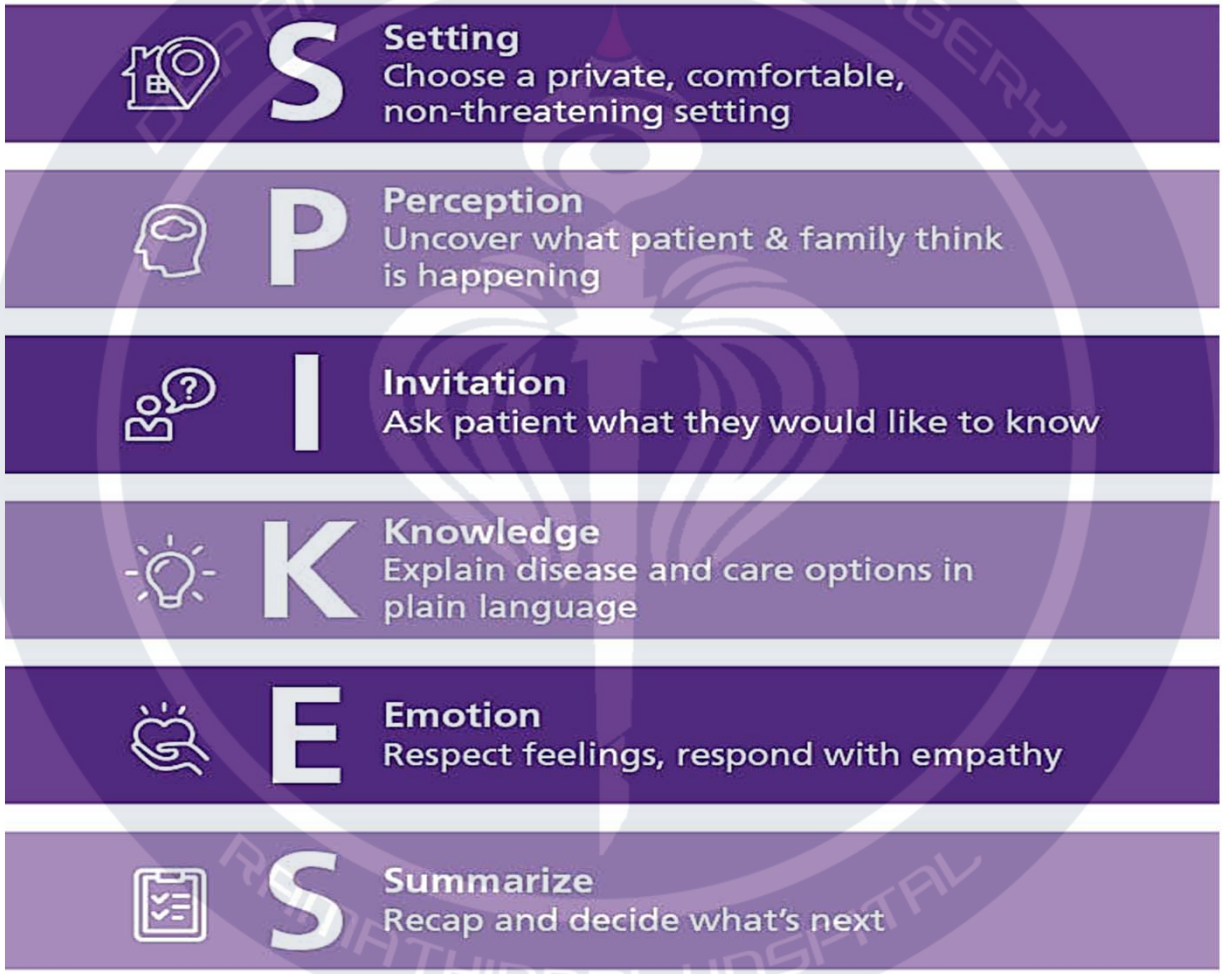
Barriers

- *Often ad hoc, not previously planned*
- *Limited preparation, no preplanned agenda*
- *Time-consuming, require communication skills & training*
- *Attendance may not include surrogates, important family members*
- *Inaccurate understanding of the current patient's medical conditions, disease progression, treatment options, potential risks, benefits & burden of treatments, key clinical outcomes, complications, prognosis and cost*
- *Inconsistent or confusing information from multiple medical experts/teams*
- *Unclear treatment goals & plans*
- *May not addressed highly sensitive issues—breaking bad news, shifting treatment approaches to EOL or comfort care, mediating disagreements or promoting consensus*
- *Insufficiently respectful of the patient & family's values, preferences, priorities and cultural traditions*

Glajchen M, Goehring A, Johns H, Portenoy R. Family meeting in palliative care: benefits & barriers. Curr. Treat. Options in Oncol. (2022) 23:658-667

SPIKES

Embrace a Patient-first Approach to Advance Care Planning Conversations



Bailey, Buckman, Lenzi, et al. The Oncologist 2000; 5: 302-311.

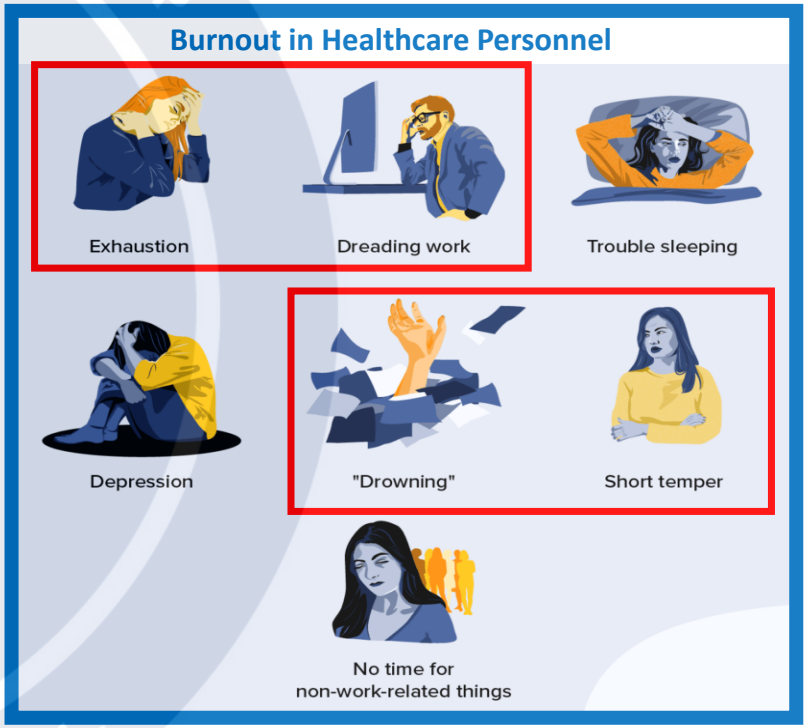
SPIKES—S—Setting

Step	Key points	Example phrases
Setting	Arrange for a private room or area. **Sit down.** Have tissues available. Limit interruptions and silence electronics. Allow the patient to dress (if after examination). Maintain eye contact (defer charting). Include family or friends as patient desires. **Surrogate medical decision maker(s).**	"Before we review the results, is there anyone else you would like to be here?" "Would it be okay if I sat on the edge of your bed?"

SPIKES—S—Setting

Counselor(s):

- mentally and cognitively preparedness
- current patient's medical conditions, staging, severity, and complications
- factual knowledge about diseases, prognosis, and treatment options
- consensus development among several medical experts involved in treatment plans & management of the patient
- invite the patient, family members, caregivers, and a surrogate decision maker to participate
- formally introduce yourself and team, build doctor-patient relationship
- know the patient, family relationship, healthcare coverage scheme, living situations, and financial status
- introduce purposes of the meeting



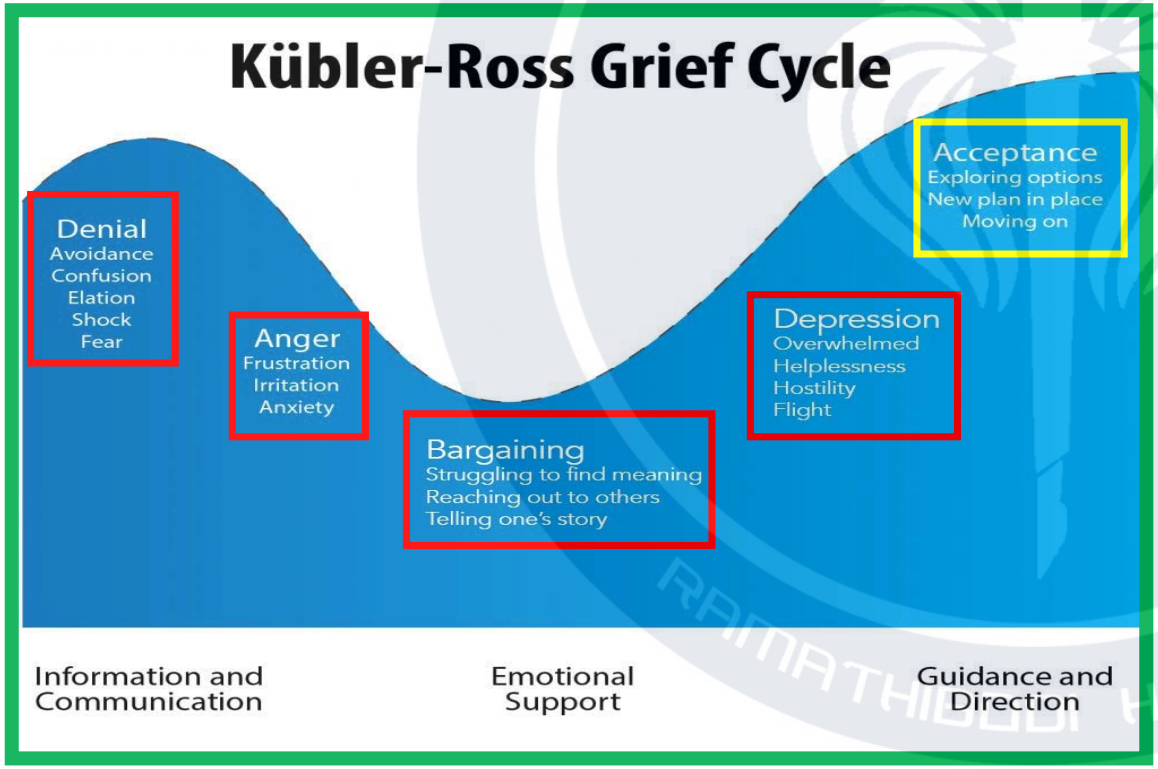
SPIKES—P—Perception

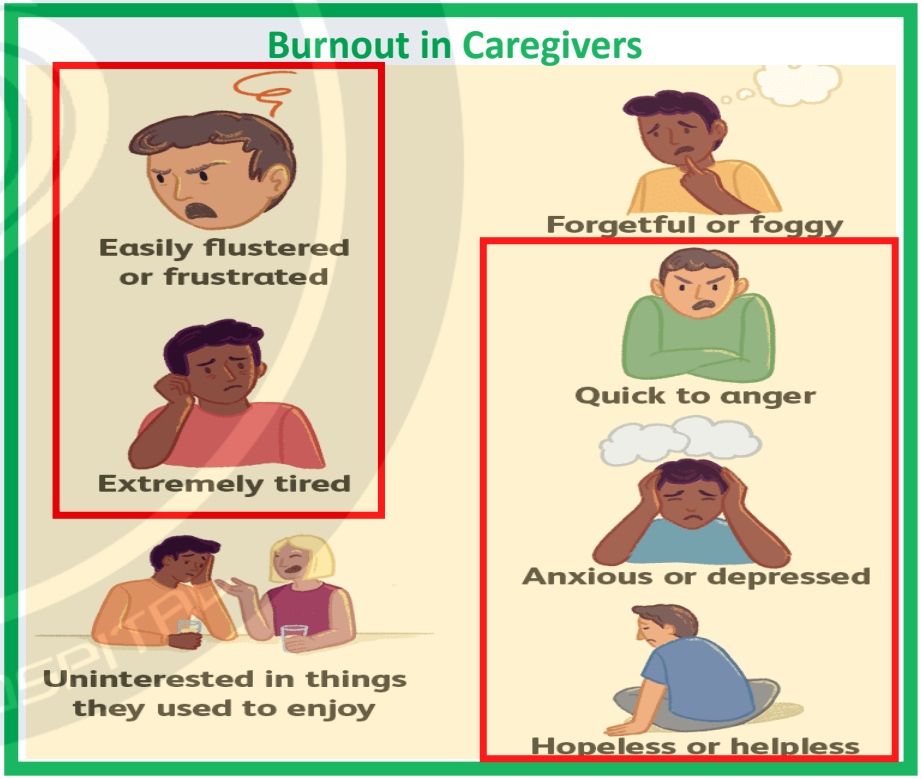
Step	Key points	Example phrases
Perception	Use open-ended questions to determine the patient's understanding. Correct misinformation and misunderstandings. Identify wishful thinking, unrealistic expectations, and denial.	"When you felt the lump in your breast, what was your first thought?" "What is your understanding of your test results thus far?"

SPIKES—P—Perception

Counselor(s):

- assess the current understandings, misinformation, misunderstandings and unrealistic expectations of the patient, family members and caregivers
- establishing, cultivating and preserving trust
- create alignment





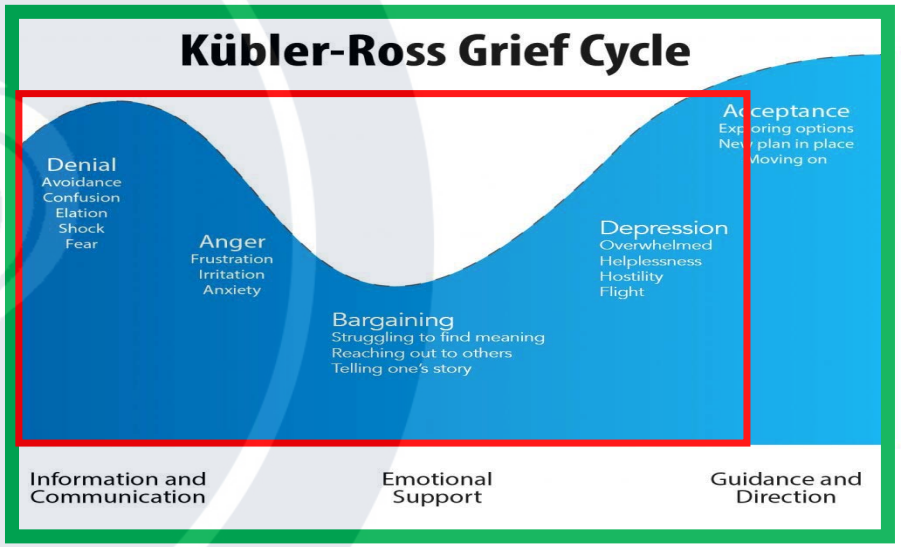
SPIKES—I—Invitation

Step	Key points	Example phrases
Invitation	Determine how much information and detail a patient desires. Ask permission to give results so that the patient can control the conversation. If the patient declines, offer to meet him or her again in the future when he or she is ready (or when family is available)	"Would it be okay if I give you those test results now?" "Are you someone who likes to know all of the details, or would you prefer that I focus on the most important result?"

SPIKES—I—Invitation

Counselor(s):

- respect privacy and maintain confidentiality
- invite and ask the patient's permission
- deliver meaningful patient engagement—the patient plays a key role in his/her own health care
- determine desire for information (high VS low desire)
- Decisional control preference—patients may be more active (self) VS more passive (physician or family members) VS shared (mixed approach)—varies by sociodemographic, culture and family dynamics
- recognize and explore emotions of the patient, family members and caregivers
- allow silence and withhold judgment
- show empathy
- may need more than one session



SPIKES—I—Invitation

Truth Telling

Rationales for lies, deceptions, misrepresentations, or failure to disclose:

- ***Patients don't want to be told***
- *Impossible to tell the whole truth*
- ***Lying, deceiving, misrepresenting, or not disclosing will prevent serious harm***
- *Telling the truth is not culturally appropriate*

SPIKES—I—Invitation

Truth Telling

- *A moral obligation?*
- *In all circumstances?*
- *Does the obligation to tell the truth overcome the desire to avoid harm? Or vice versa.*
- ***Is the harm real or imagined?***
- ***Does the patients know even though they have not been told?***
- *Conspiracy of silence?*

Ethical justification:

- ***Most patients want to know & must know in order to participate***
- **Telling the truth, avoiding deception & misrepresentation are all ways of *respecting the patient's autonomy, honoring the patient's dignity, and the essential virtue in medicine and nursing***
- **Truth-telling with compassion usually has *more beneficial than harmful consequences***

SPIKES—K—Knowledge

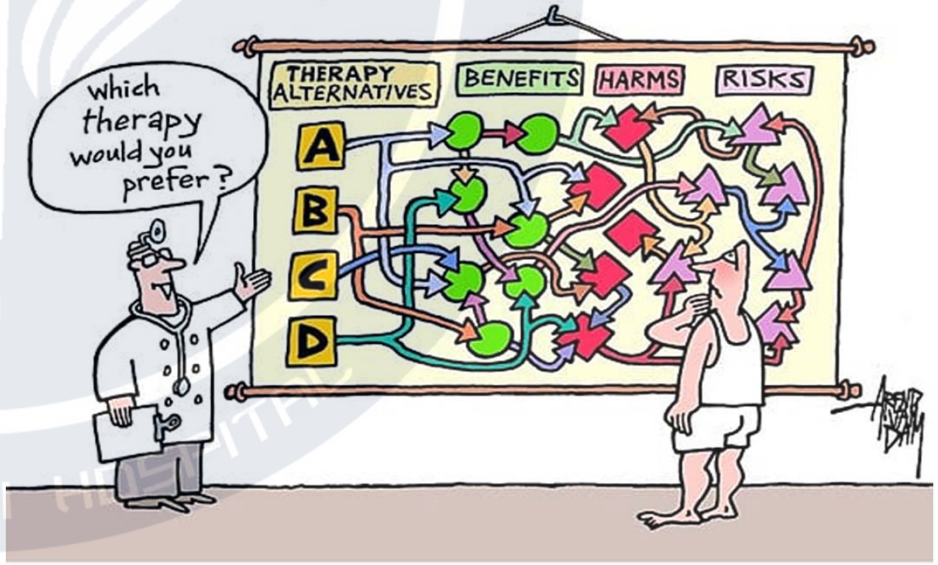
Step	Key points	Example phrases
Knowledge	Briefly summarize events leading up to this point.	"Before I get to the results, I'd like to summarize so that we are all on the same page."
	Provide a warning statement to help lessen the shock and facilitate understanding, although some studies suggest that not all patients prefer to receive a warning.	"Unfortunately, the test results are worse than we initially hoped."
	Use nonmedical terms and avoid jargon.	"I know this is a lot of information; what questions do you have so far?"
	Stop often to confirm understanding.	

Warning shots
Headlines
Avoid medical terms

SPIKES—K—Knowledge

Counselor(s):

- **Personal health literacy**—the individual' s ability to find, understand and use information to inform health related decisions for themselves and others
- **Provide necessary & consistent information to facilitate healthcare decision making**—current patient's medical conditions, complications, prognosis
- **Understand values, preferences and priorities of the patient**, family members, and caregivers
- **Explore key topics**—life goals, wishes, goals of care, views about treatments, expectations, potential benefits, burden & risks of specific treatments, **prognostic awareness, tradeoffs, fears & concerns,** and family conflicts
- **Confirm understanding**
- **Discuss goals of care**



SPIKES—K—Knowledge

Prognostic Awareness

- *Hope for the best / Prepare for the worst…*
- In clinical practice, it may be discussed in terms of life expectancy and course of illness
- Life expectancy may be discussed with a time horizon—hours to days, days to weeks, or weeks to months
- Course of illness may be described in terms of symptoms or functioning, effects on the patient, or effects on family members and caregivers
- Patients and families have varying states of prognostic awareness:
  - unknown and not wanting to know
  - unknown but wanting to know
  - inaccurate awareness
  - accurate awareness
- Discussion and disclosure of prognosis are done to correct inaccuracies and provide accurate awareness

Professor Russell Portenoy, Communication in Palliative Care: Serious Illness Discussions. MJHS Hospice and Palliative Care.

SPIKES—K—Knowledge

Trade-offs

- Which is more important?
  - quantity of life VS quality of life
  - burden of treatment VS efficacy of treatment
- Values and preferences
  - preference to survival
  - aversion to high cost
  - aversion to toxicity

Professor Russell Portenoy, Communication in Palliative Care: Serious Illness Discussions. MJHS Hospice and Palliative Care.
https://link.springer.com/content/pdf/10.1007/s11864-022-00957-1.pdf?pdf=button%20sticky

SPIKES—K—Knowledge

Trade-offs

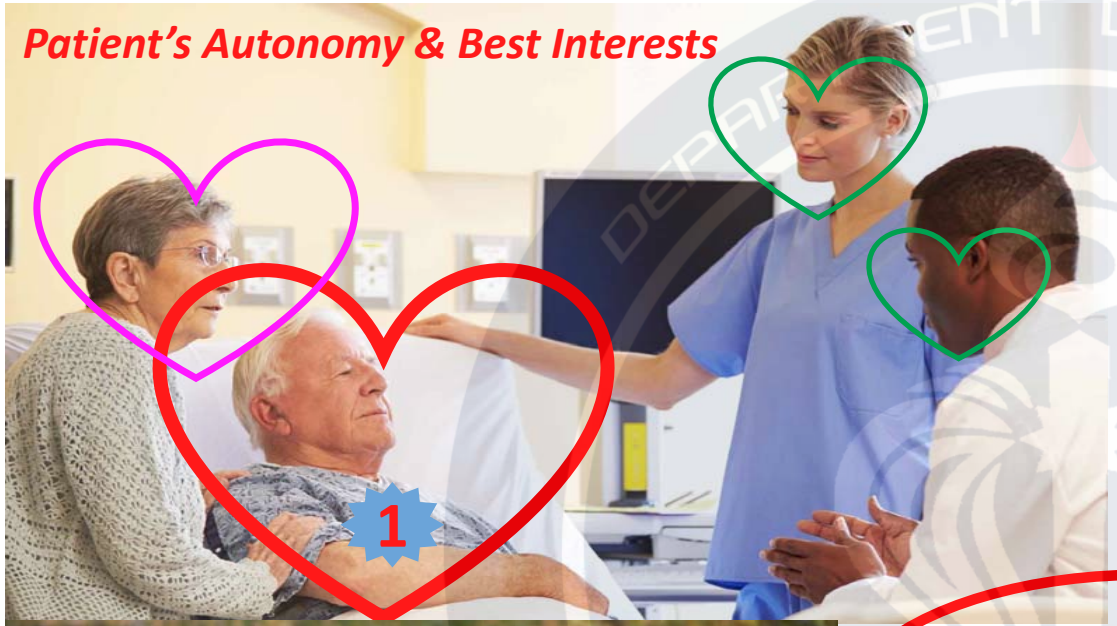
- Discussion about specific treatments is needed when consent is needed
- A treatment plan:
  - should be aligned with the patient's and/or family's values or preferences, particularly in patients and families with low health literacy
  - should have high probability of meaningfully positive clinical outcomes
  - should also plan for the healthcare personnel that will be received in the future, if the patient becomes incapable of communication

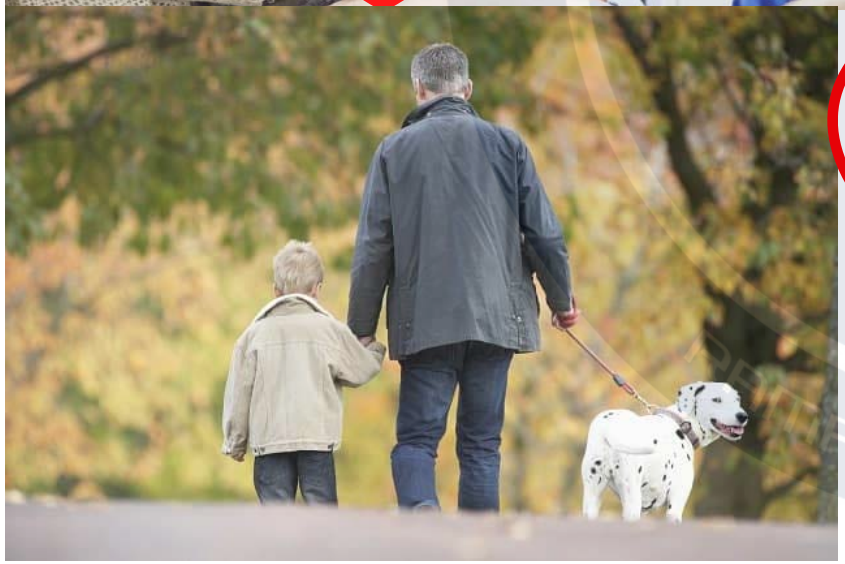
Professor Russell Portenoy, Communication in Palliative Care: Serious Illness Discussions. MJHS Hospice and Palliative Care.
https://link.springer.com/content/pdf/10.1007/s11864-022-00957-1.pdf?pdf=button%20sticky

Physician's Rescue Mission

- **"Rescue mission" dominant role of physicians**
- Accountability for patient outcomes
- Poor outcomes evoke grief & shame
- **Mortality reinforces sense of personal failure**
- **Strong personal bond with patients**
- Difficult to abort rescue when it has failed
- **Fear of litigation**
- Perceived increased difficulty prescribing opioids
- **Moral distress**
- **Palliative care = symbol of failure**

Crit Care Med. 2012 April; 40(4): 1199-1206.





Curative Intent VS Palliative Intent

Right Treatment/Intervention for
Right Patient at the
Right Time

The Holistic Patient-Centered Approach

Will Treatment/Intervention Prolong My Life?
How Will Treatment/Intervention Affect My Quality of Life?
Will Treatment/Intervention Allow Me to Preserve My Independence?

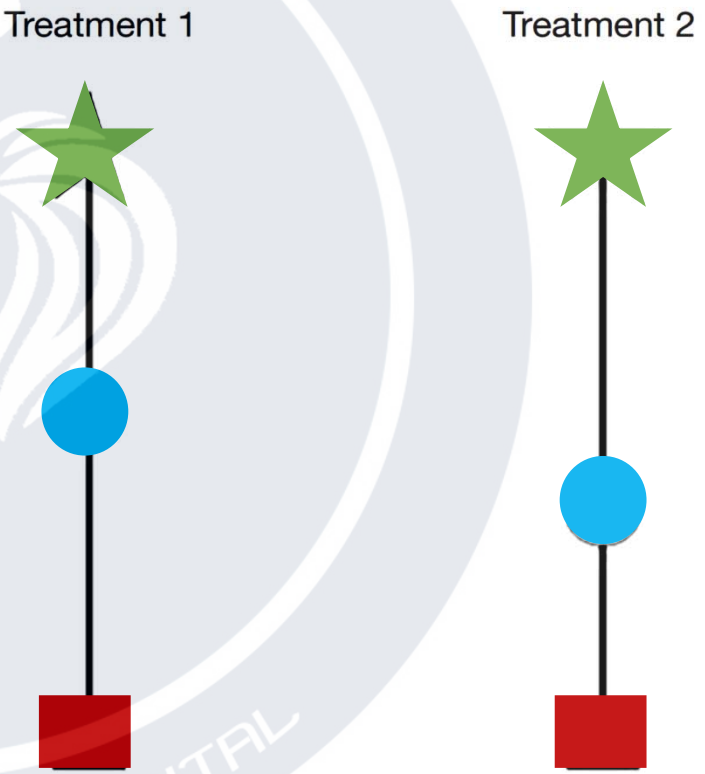
The Best Possible Quality of Life
Goal-Concordant Care

Prognostic Uncertainty
Best Case/Worst Case/Likely Case Framework

Best Case
Describe "best case" scenario
of treatment and outcomes

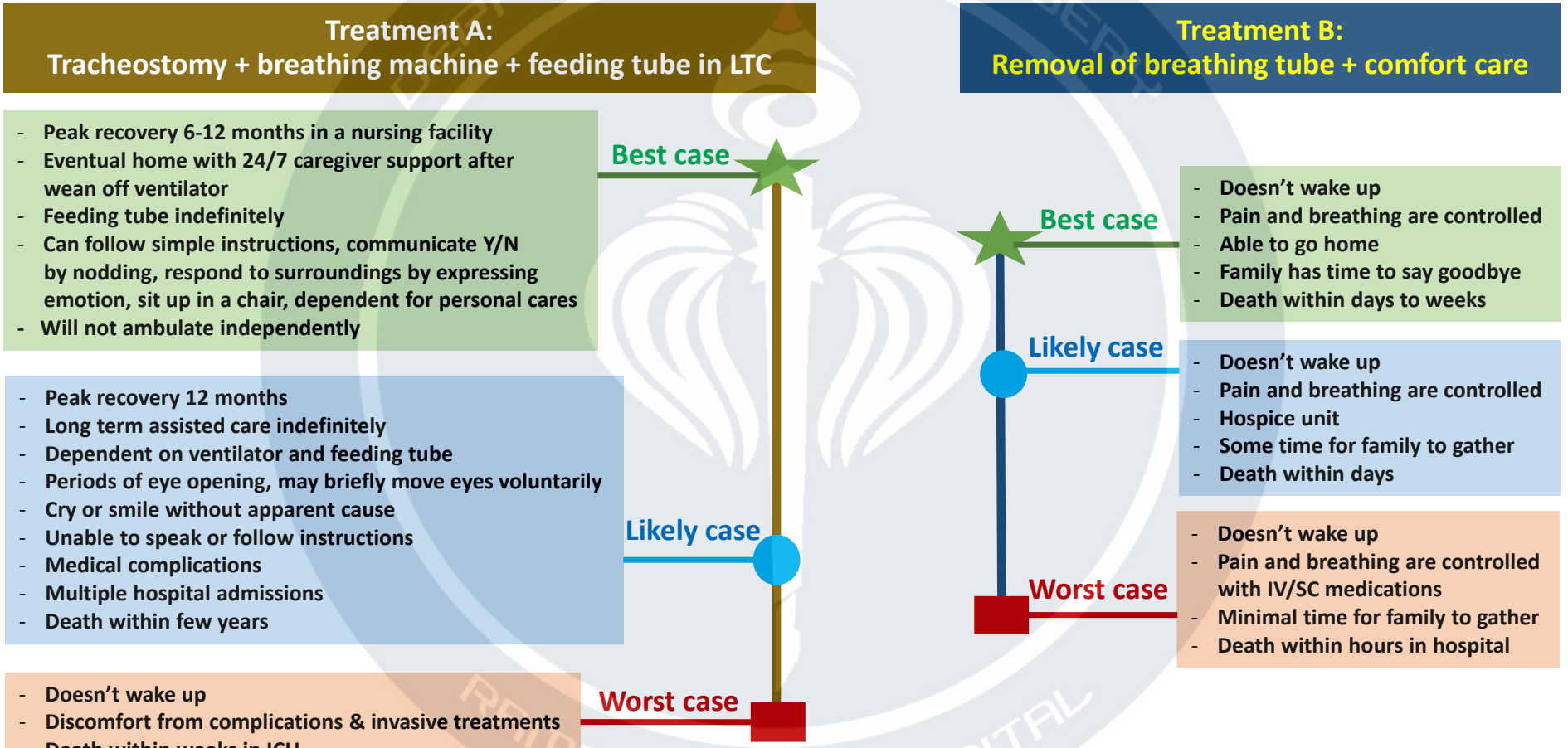
Likely Case
Describe likely outcome of
treatment and outcomes

Worst Case
Describe "worst case" scenario
of treatment and outcomes



Ann Palliat Med 2022;11(2):936-946.

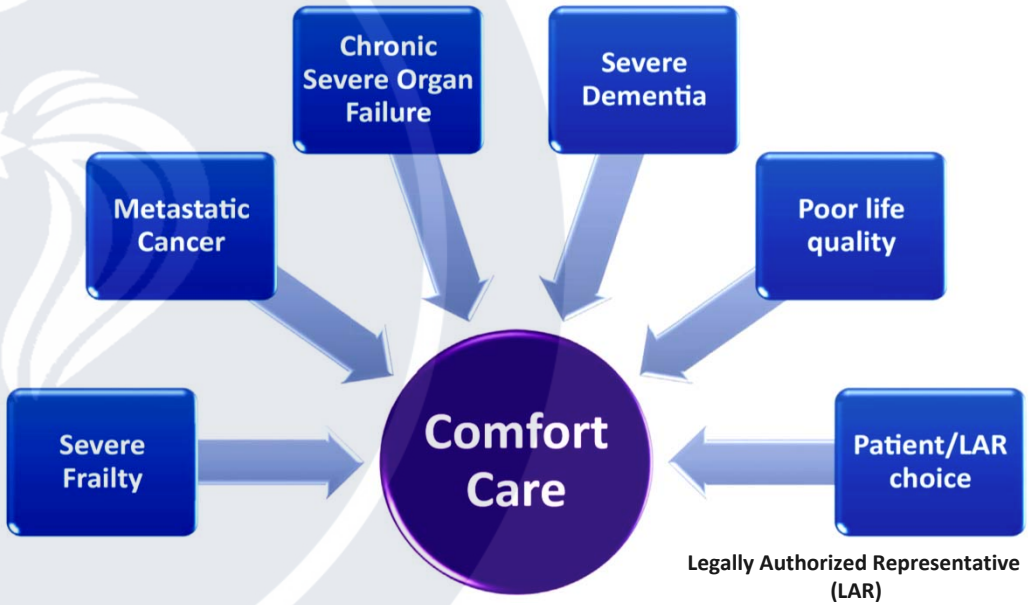
The surrogate of a 73-year-old man who was comatose due to anoxic brain injury after cardiac arrest reports that the patient values time with family and grandkids



JOURNAL OF PALLIATIVE MEDICINE. Volume 25, Number 10, 2022.

Raising Awareness for Time-Limited Trial (TLT) Discussion

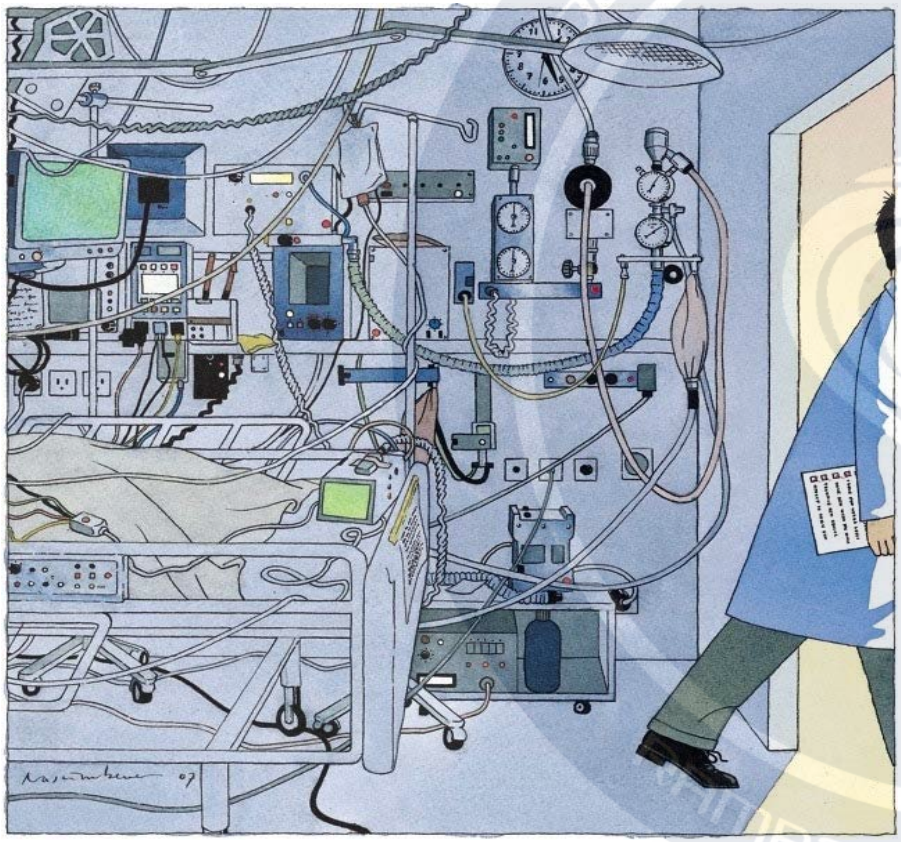
F	**Functional impairment** » Patients who are unable to carry out their instrumental or even basic activities of daily living (ADLs) independently
R	**Recurrent hospitalisations** » Patients who have 2 or more unplanned hospital admissions in the past 12 months
A	**Advanced malignancy and chronic diseases** » Examples include metastatic cancer and GOLD IV chronic obstructive pulmonary disease
I	**Irreversible organ failure** » Examples include end-stage renal failure and heart failure that exhausted existing treatment options
L	**Long hospital stay** » Patients hospitalised for a prolonged period of time in the current episode due to poor progress or complications



Surg Clin N Am 103 (2023) 1231–1251.
Intensive Care Med (2022) 48:240–241.

Life Sustaining Treatment (LST) at the End of Life

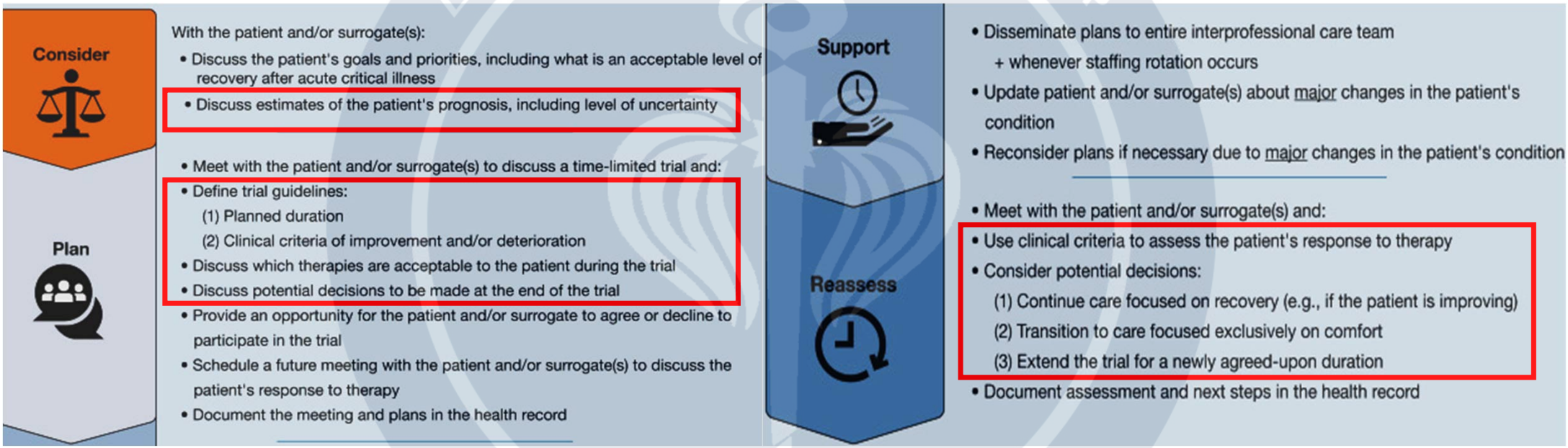
A medical intervention that saves or prolongs life without reversing an underlying medical condition



- *CPR*
- *Mechanical ventilation*
- *Dialysis*
- *Inotropes*
- *Artificial nutrition & hydration (ANH)*
- *Transfusion*
- *Antibiotics*
- *Others: tracheostomy, implanted cardiac defibrillator, etc.*

https://medicalfutility.blogspot.com/2017/06/decision-making-on-withholding-or.html

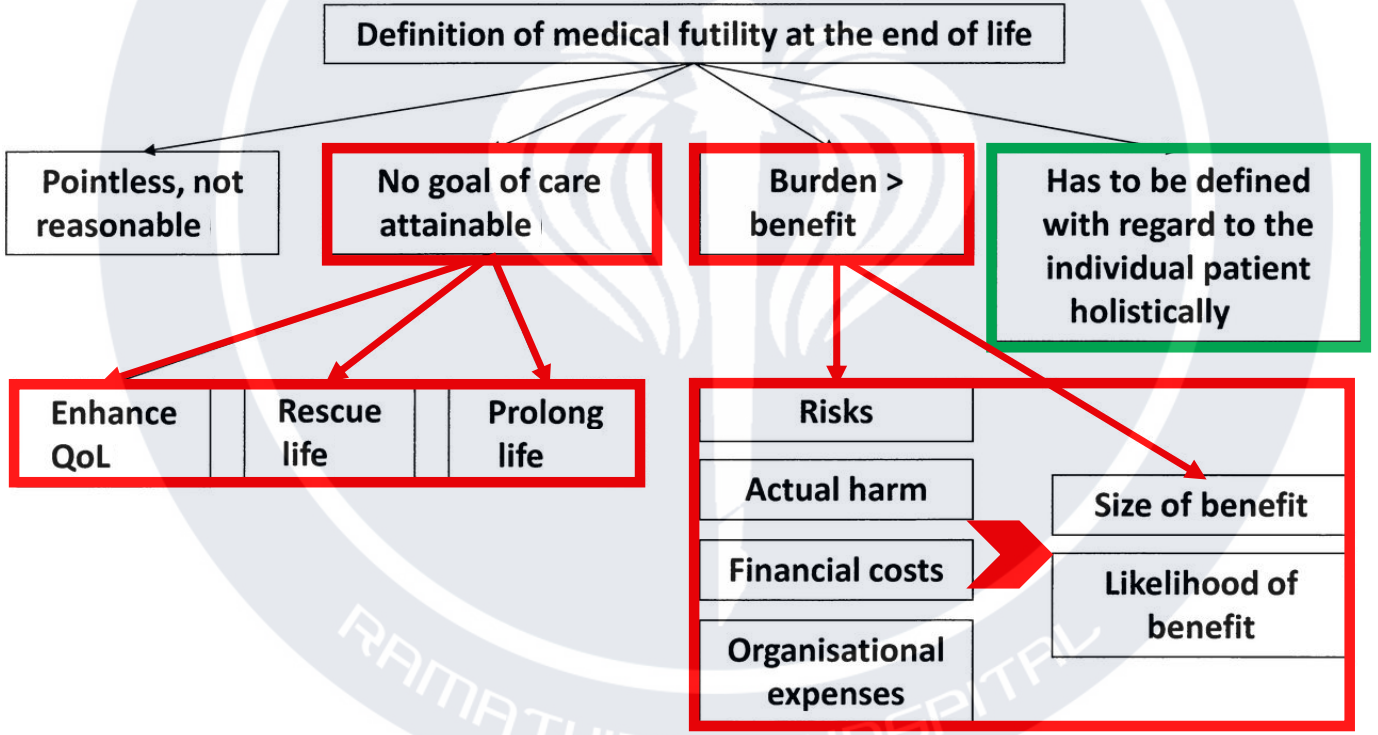
Essential Elements for Conducting a Time-Limited Trial (TLT) in Critical Care



Chest. 2023 Dec 13:S0012-3692(23)05855-5.

Medical Futility at the End of Life

- Futile (adj): pointless, incapable of producing any useful results
- A medical intervention that is likely to produce, for the patient, either no significant benefit or no benefit at all
- A medical intervention that cannot, within a reasonable probability, ameliorate, improve, or restore a quality of a quality of life that would be satisfactory for the patient



J Med Ethics. 2012 Sep;38(9):540-5.

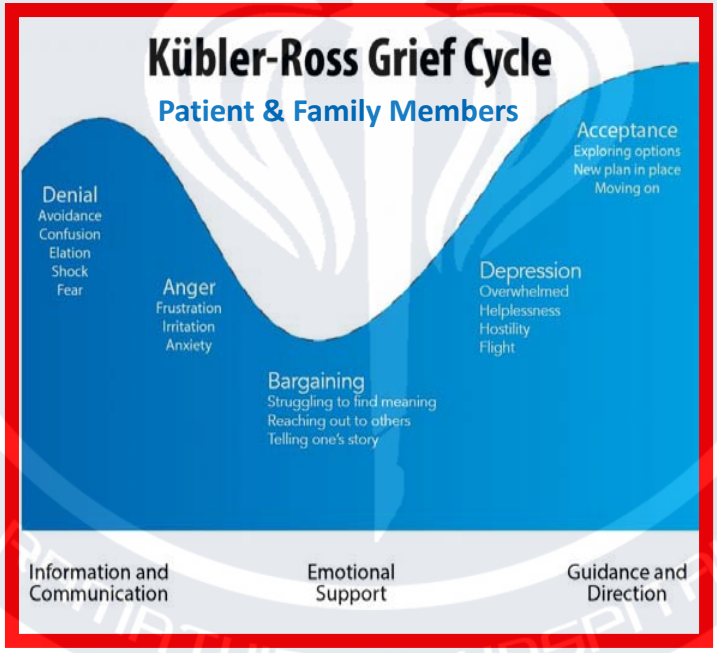
SPIKES—E—Emotion

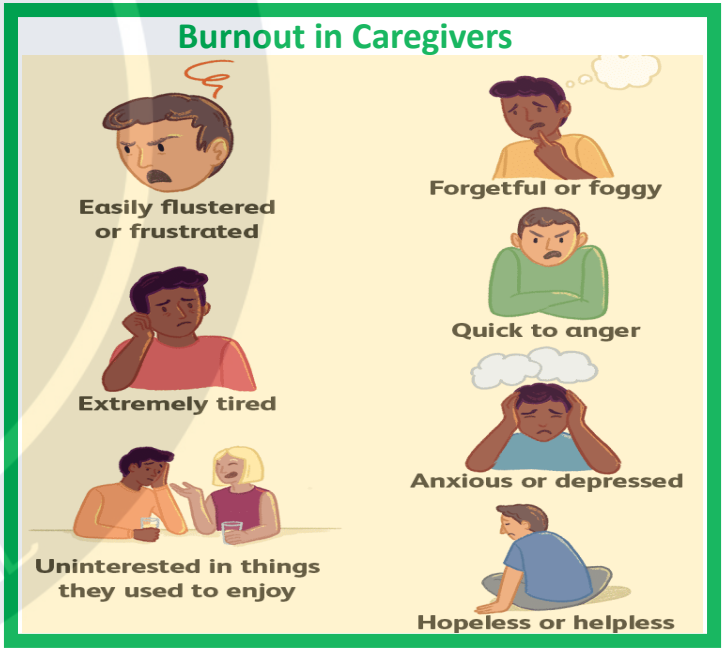
Step	Key points	Example phrases
Emotions	Stop and address emotions as they arise. Use empathic statements to recognize the patient's emotion. Validate responses to help the patient realize his or her feelings are important. Ask exploratory questions to help understand when the emotions are not clear.	"I can see this is not the news you were expecting." "Yes, I can understand why you felt that way." "Could you tell me more about what concerns you?"

SPIKES—E—Emotion

- Just being there!
- Deep listening
- Strategic silence
- Appropriate touch

- Have tissue available
- Withhold judgment
- Creative alignment





Emotion

- **Due to time constraints, clinicians tend to focus on communicating medical facts, while inadequately attending to affect, including feelings of loss, fear, and guilt.**
- For most patients and caregivers, **talking about goals of care in the setting of serious illness is scary and sad.**
- **Clinicians should watch for emotional cues and attend to patients' emotional needs.**
- **When conflict about decisions arises** between clinicians and patients or family, **addressing the underlying emotion is much more likely to lead to resolution.**
- Essential skills of emotion management:
  - **"I can see you're really concerned about this. Is it okay if we talk a bit more about what this means?"**
  - **The judicious use of strategic silence can also help to elicit patients' feelings.**

https://www.uptodate.com/contents/discussing-goals-of-care

SPIKES—S—Strategy & Summary

Step	Key points	Example phrases
Strategy and summary	Summarize the news to facilitate understanding. Set a plan for follow-up (referrals, further tests, treatment options). Offer a means of contact if additional questions arise. Avoid saying, "There is nothing more we can do for you." Even if the prognosis is poor, determine and support the patient's goals (e.g., symptom control, social support).	"I know this is all very frightening news, and I'm sure you will think of many more questions. When you do, write them down and we can review them when we meet again." "Even though we cannot cure your cancer, we can provide medications to control your pain and lessen your discomfort."

SPIKES—S—Strategy & Summary

Counselor(s):

- confirm understanding
- facilitate shared decision making
- summarize and set goals of care that respect patient's autonomy and best interests
- accurately document your conversation, ACP, GOC, treatment decisions—CPR, ET intubation, mechanical ventilation, dialysis, inotropes, tube feeding, surgery, invasive procedures & investigations, antibiotics, hydration, ICU, hospitalization, and/or morphine administration
- affirm commitment
- communicate with key clinicians, healthcare personnel, family members and caregivers
- multidisciplinary team approach and integrated care
- reevaluate periodically when appropriate

Common Pitfalls in Discussing Goals of Care

- **Starting too late or not at all — Conversations in the setting of acute hospitalization can be challenging for the patient as this is a time of crisis,** and they are likely to have **impaired decision-making capacity due to their illness and/or medications.**
- **Expecting too much too soon — Sometimes clinicians expect goals of care discussions to quickly yield dramatic changes in the plan of care, but this is not always possible.** These discussions are often a process, and sometimes the first discussion is just the beginning of a much longer decision-making journey.
- **Trying to deliver serious news (e.g., prognosis) and goals in one sitting — After receiving bad news, many patients/caregivers will require time and space to process this information.** Goals of care discussions are thus often separated in time when possible, perhaps saved for the next visit or the next hospital day.
  - **Each patient and scenario is unique;** it is important to **be consciously sensitive to the mood or feelings of the patient and family** and what they need at that time.
  - **Matching the communication style and decision-making pace to the individual patient's needs is critical.**

https://www.uptodate.com/contents/discussing-goals-of-care

Communication in Palliative Care

Benefits

- *Preplanned agenda and a goal-setting discussion*
- *Scheduled in response to specific triggers—recurrence or a life-threatening complication, progressive disease, a challenging medical decision, disagreement among the patient & family members, or clinicians regarding the patient's treatment plan, GOC or prognosis, family challenges related to a transition in care, and EOL care*
- *Attendance include appropriate medical staff/experts, surrogates and important family members*
- *A communication strategy that can*
  - *efficiently exchange information*
  - *clarify the values, preferences and priorities of the patient and family*
  - *promote consensus and shared decision making*
  - *help the patient and family engage with ACP, GOC, important medico-legal decisions*
  - *provide care that is more consistent with the patient's values & preferences*
  - *better quality of life*
  - *reduce use and cost of inappropriate life-sustaining treatments near death*
  - *reduce caregiver distress and mitigate the perception of unmet needs*
  - *improve bereavement outcomes*

Glajchen M, Goehring A, Johns H, Portenoy R. Family meeting in palliative care: benefits & barriers. Curr. Treat. Options in Oncol. (2022) 23:658-667

The Doctrine of Double Effect (DDE)

There are several elements to the doctrine of double effect:

- *The intended effect of care must be positive*
- *Any harmful effects of care should be predicted but not intended*
- *Harmful effects of care should not be used as a way to achieve beneficial results*
- *The beneficial effects of care should outweigh the harmful effects*
- *Interventions should be appropriate and proportionate*

The physician's intention is to relieve the pain, dyspnea or suffering, not to kill the patient

Core Elements of Good Death

- ***Not suffering, adequate pain and symptom management***
- ***Avoiding a prolonged dying process***
- ***Clarifying treatment decisions and preferences at the end of life*** **by the patient, family and physicians**
- ***Not being alone, feeling a sense of control*** **with spiritual & emotional sense of completion**
- ***Affirming human dignity*****—respect as an individual—a unique & worthy person,** *not a burden to family or others*
- ***Acceptance of death and adequate preparation of death*** **by the patient and family—***last wishes, unfinished business, funeral arrangement*
- ***Strengthening relationship with family and loved ones***
- ***Trust/support/comfort from medical staff and nurses***

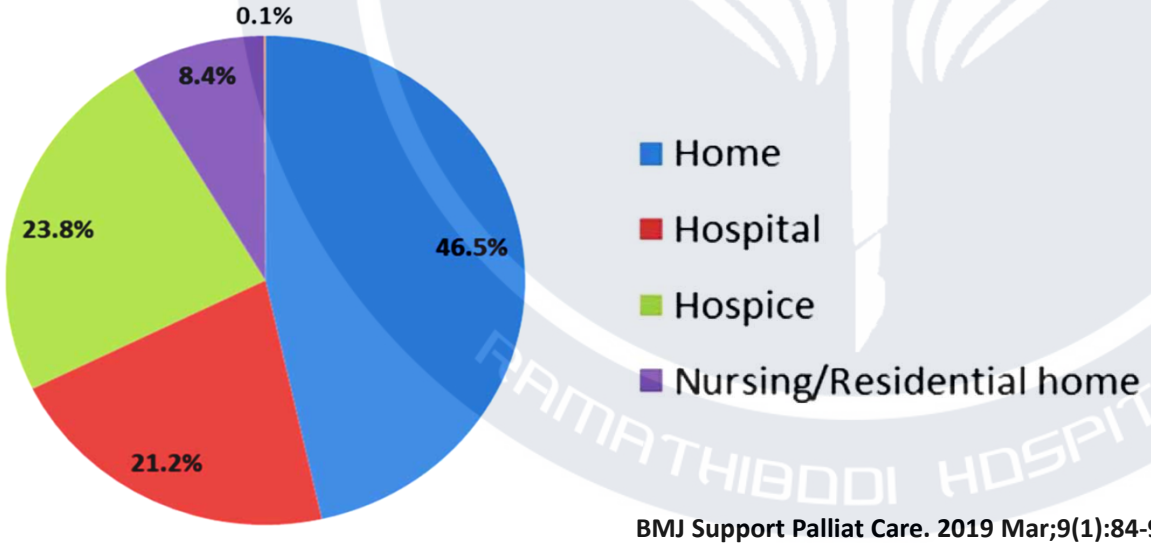
Am J Geriatr Psychiatry. 2016 April ; 24(4): 261–271.

Preferred Place of Death

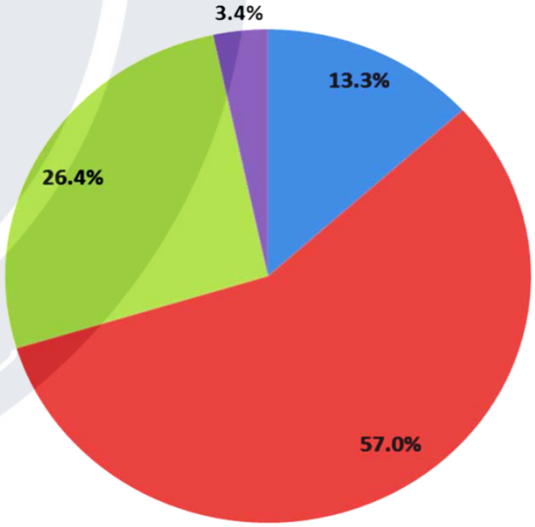
The importance of identifying preferred place of death in UK

- All deaths of patients (n=2176) known to the specialist palliative care service over a 5-year period (2009-2013).
- **73% of patients who expressed a choice about their preferred place of death**
- **69.3% who wanted to die at home were able to achieve their preferences**
- 9.5% of patients changed their preference for place of death during the course of their illness
- **30% of patients either refused to discuss or no preference was elicited for place of death**

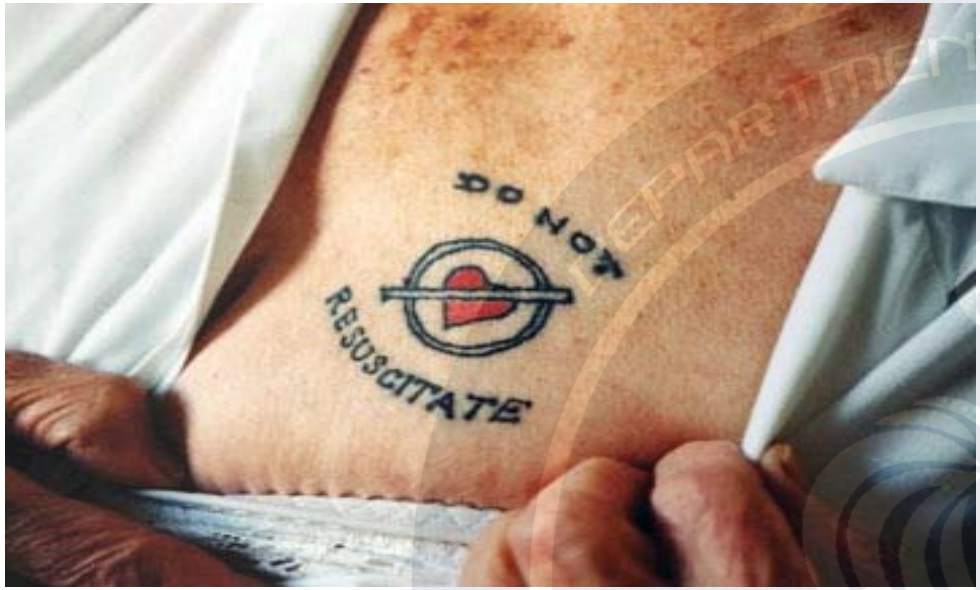
Actual place of death of patients who expressed a preference



Actual place of death of patients where preference was unknown to service

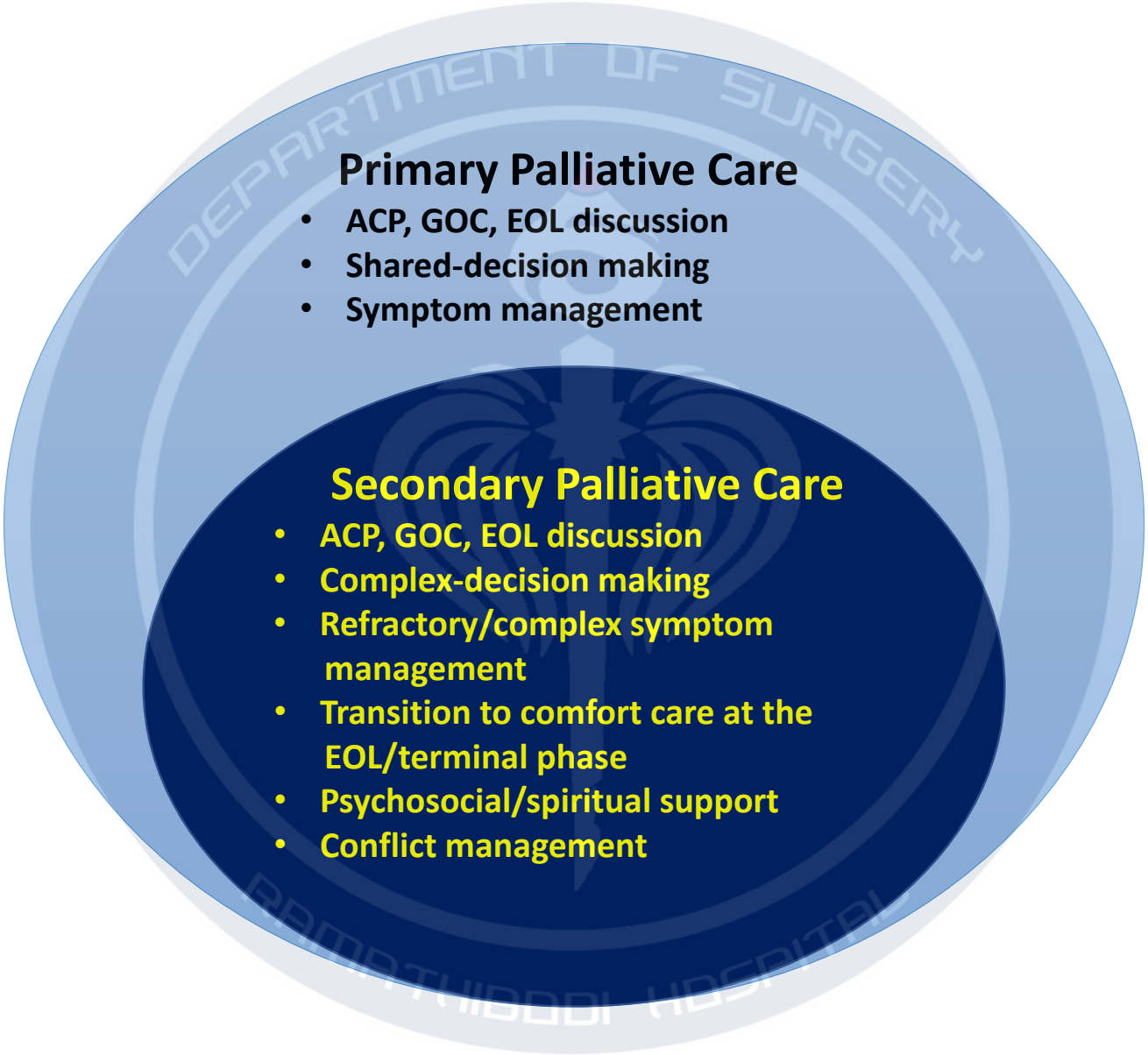


BMJ Support Palliat Care. 2019 Mar;9(1):84-91.



Notice!

"Do not resuscitate
does not mean
"do not treat."


Primary Palliative Care
• ACP, GOC, EOL discussion
• Shared-decision making
• Symptom management
Secondary Palliative Care
• ACP, GOC, EOL discussion
• Complex-decision making
• Refractory/complex symptom management
• Transition to comfort care at the EOL/terminal phase
• Psychosocial/spiritual support
• Conflict management

อนิจจัง ทุกขัง อนัตตา

เกิด แก่ เจ็บ ตาย

เมตตา

กรุณา

มุทิตา

อุเบกขา


"To cure sometimes,
to relieve often,
to comfort always"
Edward Livingston


THANK YOU

Surgical Palliation

- Surgical palliation refers to **procedures for patients with incurable disease that are intended to "relieve symptoms, minimize patient distress, and improve quality of life"** and are typically performed for relief from obstruction, bleeding, perforation, or intractable pain.
- Any procedure that relieves symptoms may be considered palliative, and the presence of an advance directive specifying comfort care or DNR order does not negate the possibility of surgery.
- **Given the incurable nature of the underlying conditions, outcomes for palliative surgeries are measured by relief of the targeted symptoms** rather than standard surgical measures, such as 30-day mortality.
- In all cases, it is important to take into **consideration individual level of frailty, symptoms, likelihood of success and durability of the procedure, availability and efficacy of nonsurgical management, and the patient's quality and expectancy of life.**

Clin Geriatr Med 35 (2019) 35–44.

Surgical Emergencies in Patients with Significant Comorbid Diseases

- Surgical emergencies in patients with significant comorbidities is common
- Surgeons must rapidly decide if surgical therapy can meet the patient's goals, and if not, help patient pursue non-operative management that may include Comfort Care
- Be aware of family or surrogate-based optimism bias, especially for critically ill patients transferred from a less complex facility
- Preoperative interventions to improve physiology and outcome are few, especially for those with time-sensitive conditions
- Intra-operative interventions should leverage a damage control approach to limit OR time and prioritize ICU-based resuscitation
- Postoperative management reflects critical care interventions and should track progress, organ failure(s), while surveilling for the development of chronic critical illness
- Goals of care reevaluation is essential for those who do not demonstrate rapid recovery
- Palliative Care Medicine consultation is appropriate for this patient population who demonstrates comorbidities that influence outcome
- A facility-based database addressing outcomes of patients who require emergency surgery facilitate performance improvement
- Conflict regarding care, especially end-of-life care, is common and benefits from a team-based approach to detection, mitigation, and management

Surg Clin N Am 103 (2023) 1231–1251.