

IN THE LITERATURE: PEER-REVIEWED ARTICLE

Which Priorities Should Guide Palliative Surgical Research?

Zara Cooper, MD, MSc and Christy Cauley, MD

Abstract

Research priorities in surgical palliative care should go beyond generating data from traditional surgical morbidity or mortality metrics. Surgical researchers can seek to better understand care management complexities of surgical patients with serious illnesses in order to gather high-quality, patient-centered data; improve surgical patients' experiences; and motivate surgical palliative care as a field.

Higher Risk for Iatrogenic Harm

More than 1 million patients with serious illnesses (ie, illnesses that are time limiting, negatively influence quality of life, and involve interventions that are burdensome to patients and families¹) undergo major surgery annually.² It is widely known that palliative care—focused on relieving pain, managing distressing symptoms, and improving quality of life^{3,4,5}—reduces health care costs⁶ and promotes better patient-physician communication.⁷ Yet seriously ill surgical patients are less likely than other seriously ill patients to receive palliative care.⁸ Two reasons for this disparity are a rescue-based cultural bias in surgery⁹ and an inability to accurately measure surgical palliative care quality solely with traditional surgical metrics (eg, morbidity and mortality). We argue here that failure to incorporate measures of seriously ill patients' experiences¹⁰ undermines care that accords patients' goals and exacerbates iatrogenic harm to patients.

Palliative Surgical Research

Measuring palliative surgical quality is complex. Surgical patients with serious illness often have competing conditions and priorities, making appropriate research outcomes difficult to identify.⁷ Patients with serious illness often prioritize health recovery outcomes (eg, time at home, relationships with loved ones)¹¹ and are unable or unwilling to participate in research. Consequently, surgical **palliative care research** has used proxy outcome measures to capture key features of patients' experiences when direct patient report is unavailable. For example, in a national study of Medicare beneficiaries with advanced cancer, patients' end-of-life care intensity and quality was measured by health care utilization.¹² Older patients who received a venting gastrostomy during their first hospital admission for a malignant bowel obstruction had fewer readmissions, less intensive unit care during their last 30 days of life, and greater hospice enrollment prior to death than patients receiving medical management.¹²

Data sources and analysis. Currently, national and quality program (eg, Medicare and the American College of Surgeons National Surgical Quality Improvement Program) data sets do not classify procedures based on surgeons' intentions, which greatly limits researchers' capacity to evaluate palliative surgery efficacy. Documenting surgeons' intentions (eg, as curative or palliative) in patients' health records provides critical data about surgical decision making and a procedure's purpose so that appropriate metrics can be used to measure surgical performance, procedural success, and quality outcomes. Collecting longitudinal data about procedures having a palliative purpose from data registries and billing codes and then measuring associations between procedures and outcomes from patients' perspectives (eg, symptom alleviation, pain relief, postoperative quality of life^{13,14}) and from clinical viewpoints (eg, infection, death, prolonged hospitalization) would provide robust assessments of procedures' quality and value to stakeholders.

Patient-centered priorities. Outcomes that express whether and to what extent patients' postoperative experiences accord with their values (eg, symptom alleviation, pain relief, postoperative quality of life, time at home, relationships with loved ones) must be prioritized in palliative surgical research. In one such study of 106 patients with advanced incurable cancer who underwent palliative surgery (ie, to control gastrointestinal obstruction, tumor-related symptoms, and jaundice), 90.7% reported symptom resolution or improvement.² Another study of surgical patients with gynecologic malignancy found that 6 months of postoperative palliative care from advanced practice nurses resulted in patients experiencing less distress and better quality of life.¹⁵ Other metrics of quality outcomes from patients' perspective include improvements in physical and psychological outcomes, functional independence, disability-free survival, social well-being, and numbers of days at home.^{13,16,17} For example, patients with symptomatic incurable cancer who received home-based postoperative palliative support had 5.5 more days at home in the last 2 months of their lives.¹⁸ Other researchers have evaluated quality in terms of patients' postoperative recovery (eg, duration of postoperative mechanical ventilation, intensive care unit stay, and inpatient status in the last 6 months of their lives).¹⁹

Communication. Communication between surgeons and patients with serious illness should be regarded as a palliative surgery quality research priority,¹⁰ since linguistic and cultural differences between patients and clinicians can influence patients' experiences.²⁰ Clinicians' clear communication about patients' prognosis, underlying illness, and changes in health states is foundational to establishing and nourishing relationships, disclosing possible benefits and risks, promoting patients' or surrogates' informed consent to or informed refusal of procedures, and affirming clinicians' ongoing support of patients and their loved ones.^{21,22} Communication is just one feature of surgeons', patients', or surrogates' understanding²³ that inform shared decision making about palliative surgical interventions. Little is known, for example, about how surgical patients with serious illnesses evaluate trade-offs (eg, between quality of life and survival duration). An abundance of literature evaluates improving communication interactions and improving documentation about advanced care planning,^{24,25,26} but patients' or surrogates' family perceptions about communication quality have been neglected.

The American College of Surgeons Geriatric Surgery Verification Quality Improvement Program to improve elders' surgical care requires that preoperative documentation include a patient's quotation about their overall health goals and goals of surgery and a

surgeon's description of how a surgical care plan is informed by the quoted goals.²⁷ Measuring adherence to this practice standard will help assess perioperative communication and palliative surgical quality and help motivate goal-concordant care.

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Zara Cooper, MD, MSc is an associate professor of surgery at Harvard Medical School in Boston, Massachusetts. She is also a trauma critical care surgeon, the Kessler Director for the Center for Surgery and Public Health, and the director of the Center for Geriatric Surgery at Brigham and Women's Hospital. Her research focuses on the intersection of surgery, palliative care, and geriatrics with the intent to integrate palliative and geriatric processes into routine surgical care to improve surgical outcomes for seriously ill patients and their families.

Christy Cauley, MD is an assistant professor of surgery at Harvard Medical School in Boston, Massachusetts. She is also a colon and rectal surgeon at Massachusetts General Hospital and a researcher at Ariadne Labs. Her research focuses on patient-centered outcomes assessment to inform surgical shared decision making in patients with serious illness.

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