End-of-Life Care of the Geriatric Surgical Patient

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KEYWORDS

• Do not resuscitate • Palliative care • Hospice • Care conferences • Goals of care • End-of-life • Surgical ethics • Palliative surgery

KEY POINTS

- End-of-life care is a broad topic that can only be done successfully with defined goals of care, familiarity with symptom management, and comfort in addressing personal and professional ethics.
- Terminal illnesses include a broad range of diseases and lengths of survival, providing unique challenges to the managing surgeon.
- Basic understanding of the differences between health care power of attorneys, advanced directives, and do not resuscitate, as well as the roles of palliative care and hospice care are key to engaging in discussions with patients and families.
- Management includes controlling pain, dyspnea, nausea and vomiting, and understanding the role and difficulties of discussing palliative surgery with patients and their families.

INTRODUCTION

"Cure sometimes, treat often, comfort always"
—Hippocrates

Nature of the Problem

Everyone dies; there is really nothing more certain in life. Despite this, a patient's preparation for the care that he or she desires at the end of life and open discussion with his or her physician remain suboptimal. In 1991, the Patient Self Determination Act was passed, which required health care institutions to inform and document patients of their rights in regards to medical decision making, including refusal of life-sustaining therapies or cardiopulmonary resuscitation. Yet, in the mid 2000s, reported rates of pre-established do not resuscitate (DNR) orders were as low as 15% in patients undergoing surgery.[1] Although surgeons are often involved in the

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Surg Clin N Am 95 (2015) 191–202
http://dx.doi.org/10.1016/j.suc.2014.09.006 surgical.theclinics.com
0039-6109/15/$ – see front matter

care of patients with life-threatening illnesses, additional single-institution reviews found surgical services lagging behind medical services in establishing DNR documentation for patients at the time of their death, with approximately 60% with established DNR orders in the records and 75% with physician-documented discussions about DNR status.[2] Surgical services also took nearly twice as long (9.8 vs 5.1 days) to establish DNR status after admission than their medical colleagues.

Comfort in discussing end-of-life care and decision making affects nearly every surgeon. The breadth of diseases managed in surgical specialties encompasses everything from cancer to dementia and trauma. This highlights not only why it is important for surgeons to be comfortable with end-of-life discussions but also why the discussions can be so difficult. Not all deaths occur the same way, especially in geriatric patients. Although patients with malignancies may suffer a slow decline, trauma patients may have been highly functional prior to their terminal traumatic event. Fig. 1 represents the varying trajectories of functional decline geriatric patients experience.[3–5] Therefore, discussion as early as possible with patients and their families about end-of-life wishes when the patient is most functional is the ideal time to establish goals of care no matter what the disease process.

GOALS OF CARE

> *"It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has"*
>
> —*William Osler*

How to Discuss Goals of Care

The most important aspect of providing good end-of-life care to geriatric patients is having a discussion about the goals of care. Ideally, this conversation should include patients when they are at their normal functional status, as this allows them to express their desires as well as establish which family members they wish to be involved in the dialogue. Several recommendations may facilitate goals of care discussions:

- Preface goals of care and DNR discussions with statements that these talks occur with all patients. This can help to diffuse patient perception that the physician believes their condition may be imminently life threatening.
- When possible, discussion points should be readdressed over multiple visits in the office or hospital to address any questions the patients may develop between encounters or changes in their wishes.

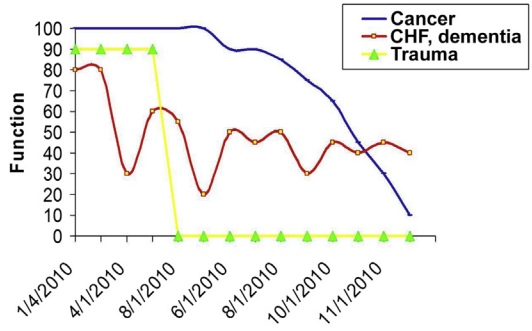

Fig. 1. The trajectory of functional decline in geriatric patients. CHF, congestive heart failure. (*Data from* Refs.[3–5])