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Perioperative Palliative Care Considerations for Surgical Oncology Nurses

Rebecca Sipples, Richard Taylor, Deborah Kirk Walker, Gulcan Bagcivan, J. Nicholas Dionne-Odom, and Marie Bakitas

Objectives: *To explore the opportunities to incorporate palliative care into perioperative oncology patient management and education strategies for surgical oncology nurses.*

Data Sources: *Articles related to palliative care and surgical oncology to determine the degree of integration, gaps, and implications for practice.*

Conclusion: *Although evidence supports positive patient outcomes when palliative care is integrated in the perioperative period, uptake of palliative care into surgical settings is slow. Palliative care concepts are not adequately integrated into surgical and nursing education.*

Implications for Nursing Practice: *With appropriate palliative care education and training, surgical oncology nurses will be empowered to foster surgical–palliative care collaborations to improve patient outcomes.*

Key Words: *surgical, oncology nursing, perioperative, palliative care, education.*

Rebecca Sipples, DNP, APRN, ACNP, ACHPN, AOCNP: *University of Alabama at Birmingham School of Nursing, Birmingham, AL.* Richard Taylor, DNP, CRNP, ANP-BC: *University of Alabama at Birmingham School of Nursing, Birmingham, AL.* Deborah Kirk-Walker, DNP, FNP-BC, NP-C, AOCN: *University of Alabama at Birmingham School of Nursing, Birmingham, AL.* Gulcan Bagcivan, PhD, RN: *University of Alabama at Birmingham, Birmingham, AL.* J. Nicholas Dionne-Odom, PhD, RN: *University of Alabama at Birmingham School of Nursing, Birmingham, AL.* Marie Bakitas, DNSc, NP-C, FAAN: *University of Alabama at Birmingham School of Nursing, Birmingham, AL.*

Address correspondence to Rebecca Sipples, DNP, APRN, ACNP, ACHPN, AOCNP, University of Alabama at Birmingham School of Nursing, 1720 2nd Avenue South, Birmingham, AL 35294-1210. e-mail: rsipples@uab.edu

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Palliative care is specialized care directed at reducing suffering and improving quality of life (QOL) for patients at any age or stage of illness and their family caregivers.[1] The National Consensus Project identifies eight domains that comprise the breadth of palliative care (Table 1).[2] These domains encompass the structure and process of care, physical, psychosocial/psychiatric, social, spiritual/religious/existential, cultural aspects of care, care at the end of life, and the ethical and legal aspects of care.[2] These domains emphasize that palliative care is holistic and uses an interdisciplinary team approach including physicians, nurse practitioners, nurses, social workers, spiritual advisors, bereavement specialists, volunteers, and others. Studies indicate that integration of palliative care concurrent with standard oncology care leads to improved health-related QOL, reduced symptom burden, decreased use of medically ineffective treatments, and improved length of survival.[3-6]

Nurses are key members of the oncology care team and it is essential that they keep abreast of new treatment developments so that their care reflects best practices. Best practices include safe administration of antineoplastic treatments (chemobiotherapy, surgery, and radiation), symptom control, survivorship, rehabilitation, and palliative and end-of-life care. Each cancer phase and subspecialty requires unique knowledge and skills. Furthermore, this care must be adapted to be provided in acute, ambulatory, and home care settings. A common thread through all of these variations and care settings is the important role of palliative care. In fact, an emerging consensus of all major oncology organizations is that the palliative care needs of patients and families begin at the time of diagnosis and continue throughout the trajectory of illness.[1,7,8] For example, the American Society of Clinical Oncology recommends that interdisciplinary palliative care begin at the time of cancer diagnosis and be provided to all patients with metastatic disease or high symptom burden.[9] The emphasis in the latter case is that palliative care can and should be provided along with curative care.

However, the practicalities of appropriately applying palliative care principles across oncology subspecialties and settings have been elusive.[10] Many oncology subspecialists are unaware of the value and extensive reach of palliative care teams, often associating palliative care only with hospice and end of life. This is especially true in oncology surgical care, where the focus is often curative.

Despite the lack of awareness about palliative care by most surgical oncology practitioners, studies have demonstrated positive patient outcomes resulting from the preoperative integration of palliative care for patients with gynecological,[11] prostate,[12] gastrointestinal,[13,14] lung,[15] neurologic,[16] and advanced cancers.[17] Palliative care has also been shown to be beneficial for patients in surgical orthopedics,[18] inpatient surgery,[19] intensive care and trauma,[20] and following outpatient surgery.[21]

Perioperative palliative care expertise extends to ethics,[22-24] communication,[25] decision-making[26] and advance care planning. For example, Cooper and colleagues[27] have identified best communication practices in geriatric emergency and trauma surgical situations to include establishing goal concordant care. Despite these positive outcomes, uptake of palliative care in surgical settings has been slow.

Palliative-specific education and training for surgical oncology clinicians is of key importance in improving surgical–palliative care collaborations. Educational recommendations have been made for surgical specialists to obtain palliative-specific training to enhance surgical training.[28-30] Dunn and colleagues,[31,32] leaders in application of palliative care in the surgery setting, have outlined palliative care core competencies and principles for surgical care (Table 2). Though written for and by physicians, many of these recommendations are applicable to the surgical oncology nurse.

Palliative care is increasingly interwoven into basic nursing education, and palliative care-specific education and training opportunities are available. The purpose of this article is to describe barriers to palliative care use in surgical oncology settings, to

TABLE 1.
The National Consensus Project Clinical Practice Guidelines for Quality Palliative Care Domains

Domain 1: Structure and Processes of Care
Domain 2: Physical Aspects of Care
Domain 3: Psychological and Psychiatric Aspects of Care
Domain 4: Social Aspects of Care
Domain 5: Spiritual, Religious and Existential Aspects of Care
Domain 6: Cultural Aspects of Care
Domain 7: Care of the Patient at the End of Life
Domain 8: Ethical and Legal Aspects of Care

Data from Clinical practice guidelines for quality palliative care.[2]