Alberta Health Services

Journal Watch – Administration & Miscellaneous – June 2018

Article:
Surgeon's perceived Barriers to Palliative and End-of-Life Care: A Mixed Methods Study of a Surgical Society.

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Review:

Strengths: Used a previously validated survey (though modified). Sought qualitative information as well. Enhancing knowledge in a still poorly-studied area.

Weaknesses: Potential for selection bias with low response rate. Unclear whether the cut-off point for the proportional analysis has been validated.

Relevance to palliative care: Surgeons are a major provider during a patient's cancer journey but can often be seen as technicians. They commonly are the most responsible provider for palliative patients at some point and have tremendous opportunity to engage the person in their illness journey and provide guidance. This study provides evidence that can be used to support arguments for increased palliative care training in the surgical specialties at the undergraduate, post-graduate and career levels.

Table 1. Surgeon-Reported Barriers to Palliative Care Using Mixed Methods Integration of Survey Scores and Qualitative Reports

Perceived barriers	*Survey results*	*Surgeons' reflections*
Surgeon knowledge and training	42.7% ($n=53$) report insufficient training in communication about end-of-life issues 40.3% ($n=50$) report insufficient training in the management of symptoms that are distressing to seriously ill patients 76.1% ($n=89$) report no formal training in palliative care	"Very difficult, little experience prior to deal with this." "Took me a while to be comfortable with talking about death early on." "I was frustrated and saddened by the mass exodus for the doors when it came time for the palliative care lecture at ASCRS in LA last week. We need more training in these important communication skills."
Communication challenges	51.6% ($n=64$) report inadequate communication between care teams and patients/families about appropriate goals of care 47.6% ($n=59$) report inadequate communication between care teams about appropriate goals of care	"Holding pressure on a bleeding ileostomy for hours, while the fellow and attending came in. The patient did get to see his family before surgery. The attending could have had better communication with the patient about goals and realistic outcomes." "Could have had better communication with team and family."
Difficulty with prognostication	45.2% ($n=56$) report unrealistic expectations about patient prognosis or effectiveness of treatment	"…female with small bowel obstruction of unclear etiology along with acute and worsening renal failure. It was unclear whether surgical intervention would be beneficial, and the patient also did not want to undergo surgery. She went home with hospice. What went well was that she was happy with her decision and not afraid. What could have gone better would have been me being more certain that I definitely would not help her if I offered her an operation." "…I once operated on a young man with carcinomatosis, implants everywhere in the abdominal cavity. Went to another major center where they reoperated on patient. I still have doubts about whether or not (a) I didn't do enough for the patient or (b) the other center did too much." "Last week I had a patient in the ICU on 4 pressors with a pH of 6.9 and a lactate of 15 for >24 hrs with flourid sepsis and multisystem organ failure. The entire care team (surgical, ICU, nursing, etc.) began to wonder how long we should continue to press on with a patient who clearly could not survive. 8 days later he is awake and alert, off pressors, on trach collar, and fully communicative. Stage IV cancer is a different story and I am a strong advocate of hospice and palliative care, but sometimes even experience clinicians cannot predict when a patient will die or recover."
Patient and family factors	61.8% ($n=81$) report unrealistic patient and/or family expectations about prognosis or effectiveness of treatment 48.9% ($n=64$) report disagreements within families about care goals 43.5% ($n=57$) report disagreements between patients/families and other care teams about care goals	"Patient with poorly responding stage 4 colon cancer in msof (multi-system organ failure) getting same chemo that already failed. Oncologists offered treatment—family wanted everything done…" "…female dying of likely ischemic bowel and having the daughter become upset with me because she could not understand why I did not want to operate."
Systemic issues	43.1% ($n=56$) report lack of advance directives 39.7% ($n=52$) report absence of surrogate decision maker for patients lacking decisional capacity 49.6% ($n=66$) report a culture of adding or continuing all life-sustaining therapies 38.3% ($n=49$) report insufficient recognition among staff or institutional leadership of the importance of optimal end-of-life care 34.9% ($n=45$) report inadequate support services 32.8% ($n=42$) report lack of consultants with special expertise in management of symptoms that are distressing to patients 39.5% ($n=51$) report insufficient continuity of care during transitions into higher level of care 53.2% ($n=66$) report competing demands for time	"…middle aged man with end stage CHF, COPD, and CKD treated laparoscopically for incarcerated ventral hernia. Prolonged postop course with recurrent arrhythmias. Bad: no advanced directive; family and patient disagreed on goals/treatment; last-minute flip flops on resuscitation/DNR; poor specialist communication of prognosis…" "I don't think that we do a good job educating families (or members of society) about end of life. Everyone just continues to think 'you've got to do something.'" "…In my opinion, the biggest gap is that our country views death as a taboo subject and as a failure, instead of treating it like another part of life that has its own value and meaning." "Would appreciate easier access to providers with a focus on end-of-life to collaborate in care for the patient and family." "… women with metastatic rectal cancer, coord(ination) of home health/hospice could have been better" "We need a better palliative care service. As surgeons, we just can't fill that role adequately, though I feel we should stay involved."

ASCRS, American Society of Colon and Rectal Surgeons; CHF, congestive heart failure; CKD, chronic kidney disease; COPD, chronic obstructive pulmonary disease; DNR, do-not-resuscitate order.