AAST PALLIATIVE CARE COMMITTEE PRODUCT

GOALS OF CARE: A PRIMER FOR SURGEONS

FROM THE ACS TQIP PALLIATIVE CARE BEST PRACTICES GUIDELINES:

- "Palliative care is a philosophy of care focused on **improving the quality of life** for patients with serious illness, and their families."
- "Palliative care is delivered concurrently and integrated with other curative or life-sustaining therapies."

The first step to improve quality of life is to establish shared decision-making to set the stage for an initial discussion to address **overarching goals of care** and **code status**, in the context of the patient's goals, preferences, and values.

TARGETED PATIENT POPULATION:

Trauma and emergency general surgery patients with one or more of the following characteristics:

- Potentially life-threatening or disabling acute condition (injury or illness)
- Significant comorbid burden
- Frailty

TIMING OF INITIAL DISCUSSION:

- As soon as possible
- Within the first 24 hours after admission, and no later than 72 hours after admission
- If operative intervention is being considered, ideally prior to the operation

DETERMINATION OF THE PATIENT'S DECISION-MAKING CAPACITY:

- Decision-making capacity means that the patient must be able to understand, reason through, and communicate choices pertaining to their medical condition and treatment options.
- Any physician can make this determination.
- When in doubt, consult psychiatry.

IF THE PATIENT LACKS DECISION-MAKING CAPACITY, IDENTIFY A SURROGATE:

- Legal documentation of surrogate and preferences (advance directive, living will, durable power of attorney for health care, POSLT/MOLST)
- If no legal documentation is available, identify an informal surrogate (order of priority may vary by state statute): spouse; adult child; parent; adult sibling, etc.
- If no family, a person familiar with the patient's goals, preferences, and values.
- Unbefriended patients (no identifiable surrogate): seek a court-appointed surrogate; until this is accomplished, the best interest standard applies.

THE CONTENT OF THE INITIAL DISCUSSION:

OVERARCHING GOALS OF CARE

- **Explain** diagnosis, prognosis, and treatment options.
- **Listen** in order to understand and establish the patient's goals, preferences, and values.
- **Tailor** the treatment options to those that most closely align with the patient's goals, preferences, and values.
- Establish preferences around other more general medical therapies:
  - "Artificial" hydration and nutrition
  - Renal replacement therapy
  - Tracheostomy in the management of chronic respiratory failure or inability to protect airway
  - Feeding access, including "temporary" nasoenteric tubes or "permanent" surgical feeding tubes in the management of dysphagia or other inability to self-sustain nutrition

CODE STATUS

Interventions to manage cardiopulmonary arrest and acute clinical deterioration exclusive of cardiopulmonary arrest should be carefully discussed in a cohesive manner in the overall context of the patient's goals, preferences and values.

- Patient's wishes for **CPR** in the context of **cardiopulmonary arrest**:
  - YES includes intubation and mechanical ventilation; chest compressions; and defibrillation.
  - NO does not provide any of the above interventions. The patient will not be resuscitated.
- Patient's wishes for intervention in the context of acute clinical deterioration **exclusive of cardiopulmonary arrest:**
  - PROVIDE / DO NOT PROVIDE intubation and mechanical ventilation
  - PROVIDE / DO NOT PROVIDE noninvasive mechanical ventilation
  - PROVIDE / DO NOT PROVIDE electrical cardioversion
  - PROVIDE / DO NOT PROVIDE vasopressors / inotropes
  - DO / DO NOT transfer to a higher level of care

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