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Palliative care and trauma surgery: still too little, too late

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The retrospective study by Fakhry *et al*[1] is one of a growing number of publications in palliative medicine to use big data.[2] A clear strength of this work is its large sample size, and the evaluation of both Surgical and Trauma patients' experiences in comparison to Medical patients, and also cataloging illness severity. Although its findings are intriguing and add to the general discourse calling for greater participation of palliative care in the treatment of those hospitalized for trauma and surgery,[3 4] the results are unfortunately not surprising.[5]

Widespread underutilization of palliative care has been well documented.[6] However, use of the palliative Z51.5 International Classification of Diseases, 10th Revision code on Medicare claims is found to undercount specialist palliative consults when compared with direct provider survey of prevalence,[7] with a sensitivity ranging from 11% to 84% as a marker for specialist palliative services.[8] Further, this code may be applied when palliative services are supplied by non-specialist providers, in situations where comfort measures only are employed, or when a hospice disposition is being pursued.[8] Therefore, the authors' use of the Z51.5 code as a proxy for palliative care services, underrepresents specialist palliative care utilization.

This coding challenge was likely distributed evenly across study groups. As such, it is significant that mean Elixhauser Scores for patients across all groups coded as receiving palliative care were almost twice those who did not, and frailty scores were similarly greater; supporting relative comfort engaging palliative care with a specific patient phenotype. The American College of Surgeons (ACS) Trauma Quality Improvement Program (TQIP) has advocated for incorporation of palliative principles on initial assessment of all trauma patients, and for further incorporation of the trauma palliative care bundle within the first 72 hours of presentation, including specialist palliative consultation as indicated.[9] When coupled with the ACS Geriatric guidelines,[10] arguably more of those in the Trauma group should have had exposure to palliative services, and easily most if not all of those in all three groups found to have died in the hospital. Although smaller studies have found suboptimal adherence to TQIP guidelines,[6] the magnitude of this data set and volume of patients included shows it is time to move beyond documenting unmet palliative needs and calls for increased palliative services[1 5] to actions incorporating increased use, such as protocols and pathways.[11 12]

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