

Primary palliative care in acute care surgery: an American Association for the Surgery of Trauma Critical Care Committee and Palliative Care Committee clinical consensus document

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INTRODUCTION

The American Association for the Surgery of Trauma (AAST) Critical Care Committee develops clinical consensus documents to provide practical guidance on topics based on literature review, available evidence, and expert consensus. In collaboration with the AAST Palliative Care Committee, committee members sought to establish clinical consensus pertaining to incorporation of primary palliative care in acute care surgery. Primary palliative care is the provision of palliative care by the primary healthcare team rather than a specialty palliative care consultant. Primary palliative care includes but is not limited to providing patient-centered care, psychosocial and spiritual support, serious illness communication, pain and symptom management, advance care planning (ACP), and shared decision-making with a focus on establishing medical goals that align with the patient's values. Shared decision-making acknowledges the importance of the patient's autonomy and values while integrating medical expertise and evidence-based information to arrive at treatment decisions that align with the patient's overall goals. In this article, we address the provision of primary palliative care by the acute care surgeon.

METHODS

A subgroup was formed composed of the document's authors and inclusive of members of both the AAST Critical Care and Palliative Care Committees. The subgroup formulated the objective of the clinical consensus document and developed a series of practical clinical questions of interest to the bedside acute care surgeon. The highest priority clinical questions were selected for inclusion. Authors were assigned a question and then individually performed a literature review and developed a recommendation based on available evidence, society guidelines, and existing reviews. Recommendations, references,

and content were reviewed by the subgroup and revised based on feedback to achieve consensus. The subsequent document was distributed to the subgroup and members of both AAST Committees for review and revision to achieve final consensus. A summary of recommendations is provided in [table 1](#).

What screening tools are available to identify which acute care surgery patient populations may benefit from palliative care?

Recommendation

Systematic screening and identification of palliative care needs among acute care surgery patients should be initiated at time of admission and completed within 24 hours. The 'Surprise Question' is useful for screening diverse patient populations for palliative care needs.

Discussion

Identifying the need for early incorporation of palliative care is key to optimizing its benefits. This is particularly true in the acute care surgery population, as a patient's status may change rapidly. Consistent implementation of a screening system for palliative care is essential and should be initiated at hospital admission and completed within 24 hours.¹ While numerous screening tools exist, validation and utility for prognostication remain limited. Among available screening tools, the 'Surprise Question' is widely recognized. Validated in various settings across diverse patient populations, the simplicity belies its effectiveness.²⁻⁴ Practitioners need only ask themselves, 'Would you be surprised if this patient were dead in 12 months?' For patients prompting a 'no' or 'maybe' response, early consideration of palliative care should be strongly considered.

The American College of Surgeons (ACS) Trauma Quality Improvement Program Palliative

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Table 1 Primary palliative care consensus summary

Question	Recommendations	References
Screening tools	<ul style="list-style-type: none"> ▶ Surprise Question ▶ ACS TQIP Palliative Care Best Practices Guidelines 	<ul style="list-style-type: none"> ▶ Trauma Quality Improvement Project (TQIP) Palliative Care Best Practices Guidelines. Available at: https://www.facs.org/medial/g3rfeqcn/palliative_guidelines.pdf.¹
Frameworks	<ul style="list-style-type: none"> ▶ REMAP (VitalTalk) ▶ Best Case/Worst Case 	<ul style="list-style-type: none"> ▶ VitalTalk. Available at: https://www.vitaltalk.org/resources/quick-guides/.¹¹ ▶ Taylor LJ, Nabozny MJ, Steffens NM, <i>et al</i>. A framework to improve surgeon communication in high-stakes surgical decisions: Best Case/Worst Case. <i>JAMA Surg</i> 2017 Jun 1;152(6):531–8.¹³
Death and dying	<ul style="list-style-type: none"> ▶ Relieve distressing physical and psychosocial symptoms. ▶ Elicit patient goals, values, and priorities. ▶ Preserve human dignity and autonomy at end of life. 	<ul style="list-style-type: none"> ▶ Kon AA, Shepard EK, Sederstrom NO, Swoboda SM, Marshall MF, Birriel B, <i>et al</i>. Defining futile and potentially inappropriate interventions: a policy statement from the Society of Critical Care Medicine Ethics Committee. <i>Crit Care Med</i> 2016;44(9):1769–74.¹⁷
Goals of care	<ul style="list-style-type: none"> ▶ Clarify within 24 h if feasible, before operative intervention, and no later than 72 h after admission. ▶ Determine treatment options that most closely align with the goals, values, and preferences of the patient. 	<ul style="list-style-type: none"> ▶ Kodadek LM. Ethical challenges when establishing goals of care in the acute care surgical setting. <i>J Clin Ethics</i> 2022;33(2):146–50.¹⁹ ▶ Cook MR. Goals of care: understanding the outcomes that matter most. <i>Surg Clin North Am</i> 2019 Oct;99(5):833–47.²⁶
Code status and advance care planning	<ul style="list-style-type: none"> ▶ Code status is a medical order and should be established early through collaborative conversations. ▶ Advance care planning documents are not medical orders, but may help guide difficult conversations. 	<ul style="list-style-type: none"> ▶ Shapiro ME, Singer EA. Perioperative advance directives: do not resuscitate in the operating room. <i>Surg Clin North Am</i> 2019;99(5):859–65.²³
Specialty palliative care	<ul style="list-style-type: none"> ▶ Appropriate for complex care needs/transitions, refractory pain, or other challenging symptoms. ▶ Appropriate to assist with conflict among treating physicians and/or family members/surrogates. 	<ul style="list-style-type: none"> ▶ Spencer AL, Miller PR, Russell GB, Cornea I, Marterre B. Timing is everything: early versus late palliative care consults in trauma. <i>J Trauma Acute Care Surg</i> 2023 May 1;94(5):652–58.³⁰
Capacity	<ul style="list-style-type: none"> ▶ May be determined by any licensed clinician. ▶ Decision specific and applies in medical setting. ▶ Not synonymous with legal determination of competence. 	<ul style="list-style-type: none"> ▶ Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. <i>N Engl J Med</i> 1988 Dec 22;319(25):1635–8.³⁴
Role of surgery with comfort focus	<ul style="list-style-type: none"> ▶ Surgery should be carefully considered based on individual preferences, impact on quality of life, and potential for symptom management. 	<ul style="list-style-type: none"> ▶ Bélanger E, Rodríguez C, Groleau D. Shared decision-making in palliative care: a systematic mixed studies review using narrative synthesis. <i>Palliat Med</i> 2011;25(3):242–61.⁴⁰
Non-beneficial surgery	<ul style="list-style-type: none"> ▶ Surgeons should avoid non-beneficial surgery. ▶ Provide recommendations that align with the patient's values and goals. 	<ul style="list-style-type: none"> ▶ Cooper Z, Koritsanszky LA, Cauley CE, Frydman JL, Bernacki RE, Mosenthal AC, Gawande AA, Block SD. Recommendations for best communication practices to facilitate goal-concordant care for seriously ill older patients with emergency surgical conditions. <i>Ann Surg</i> 2016 Jan;263(1):1–6.⁴⁶
Surgical training and healthcare systems	<ul style="list-style-type: none"> ▶ Palliative care is a core component of healthcare systems. ▶ Facilitate trainee exposure, courses, rotations, and advanced training with palliative care fellowship. ▶ Purely consultative approaches lead to underutilization of palliative care. 	<ul style="list-style-type: none"> ▶ Ballou JH, Brasel KJ. Teaching palliative care in surgical education. <i>AMA J Ethics</i> 2021 Oct 1;23(10):E800-805.⁵³

ACS, American College of Surgeons; TQIP, Trauma Quality Improvement Program.

Care Best Practices Guidelines advocate for the integration of the 'Surprise Question' into a comprehensive screening process.¹ The screening approach stratifies patients into different categories (table 2) and recommends appropriate palliative care interventions (table 3). Those who screen negative typically represent a younger cohort with a favorable prognosis. In contrast, patients experiencing potentially life-threatening or disabling injuries, particularly those with

baseline comorbidity, frailty, or older age, should be considered for early incorporation of palliative care.

While the 'Surprise Question' is easily applied to diverse patient populations, other screening instruments have been validated within specific patient populations. For instance, tools are available to assess appropriateness of palliative care among older people with multiple advanced chronic illnesses and those with dementia.^{5–7} The selection of a screening

Table 2 ACS Trauma Quality Improvement Program Palliative Care Best Practices Guidelines: palliative care screening for injured patients

	Previous functional status	Injury severity	Disability	Surprise Question response*
Negative screen	Healthy, no serious chronic illness	Non-life-threatening injuries	Non-disabling injuries	Yes
Positive screen (category 1)	One or more serious illnesses, frailty, older age	Potentially life-threatening injuries	Potentially disabling injuries	Maybe or No
Positive screen (category 2)	Chronic serious illness, frailty, older age	Anticipated high risk of hospital mortality due to injury	Permanent disability or functional outcome incompatible with patient's wishes	No

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*Surprise Question: Would you be surprised if this patient were dead in 12 months?

ACS, American College of Surgeons; TQIP, Trauma Quality Improvement Program.

Table 3 ACS Trauma Quality Improvement Program Palliative Care Best Practices Guidelines: palliative care screening recommendations for injured patients

Positive screen category	Assessment and recommendations
Category 1	<p>Uncertainty regarding long-term functional recovery or survival due to severe traumatic injuries, age, frailty, comorbidities, or a combination of these factors.</p> <ul style="list-style-type: none"> ► Provide support to patient and patient's family. ► Establish advance care planning. ► Engage in goals of care discussions. ► Assess and treat pain and other symptoms. ► Clarify resuscitation preferences (code status). ► Consider time-limited trials. ► Consider palliative care specialty consultation.
Category 2	<p>Major life-threatening or disabling traumatic injuries, or lesser injuries with serious underlying comorbidities, frailty, or advanced age place patient at high risk of in-hospital death or discharge to dependent care.</p> <ul style="list-style-type: none"> ► Provide support to patient and patient's family and/or surrogate. ► Engage in focused goals of care discussions. ► Consider comfort measures and withdrawal of life-sustaining therapy. ► Consider Do Not Attempt Resuscitation order. ► Assess and treat pain and other symptoms. ► Offer spiritual support and bereavement. ► Consider transitions in care. ► Consider end of life care and hospice. ► Notify organ procurement organization if appropriate.

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tool must align with both patient characteristics as well as needs and preferences. Validation metrics vary for each tool, encompassing factors such as short-term mortality, discharge disposition, and resource utilization.

What frameworks are best suited to allow acute care surgeons to deliver serious news, discuss prognosis and treatment options, and assist with complex shared decision-making with patients, their families, and surrogate decision-makers?

Recommendation

Validated tools and frameworks are available to deliver serious news and share several common themes. Important elements include assessing the patient/family/surrogate's understanding and preferences, communicating the medical update, and responding to emotion. The REMAP framework created by VitalTalk and the Best Case/Worst Case framework may be of particular interest to acute care surgeons.

Discussion

Delivering serious news, discussing prognosis, and assisting with complex shared decision-making are integral aspects of being an acute care surgeon. Managing uncertainty and complex emotions is often compounded by an external time pressure imposed by the clinical situation. The difficulty is made even greater when the short- and long-term prognosis for a developing clinical problem is unclear. A framework to guide conversations improves the quality of the communication and multiple patient-reported outcomes across a range of complex situations.^{8–10}

It is imperative that surgeons prepare for these conversations. One should gather the necessary medical information and meet with other clinicians to agree on the conversation agenda, clinical details, treatment options, and recommendations to avoid confusion during the meeting. The conversation should occur in a quiet and safe place that minimizes distractions. Everyone is encouraged to sit down rather than stand during the conversation. It is important to check that the 'right' people are present from the patient/family/surrogate perspective. The team leader should introduce everyone in the room and ask permission to start.

Important elements of available validated tools include assessing the patient/family/surrogate's understanding and preferences, communicating the medical update, and responding to emotion.¹⁰ These must be addressed before engaging in a discussion about treatment options or making recommendations. The situation may mandate quick decisions, but if time is not taken to attend to the emotional response, the patient/family may have difficulty processing the information needed to make decisions. Here we recommend two specific and commonly used frameworks with an established literature base.

One structured approach is the REMAP framework created by VitalTalk.¹¹ It starts with 'Reframing' the situation by first assessing the patient/family/surrogate understanding and perspective, then delivering a medical update using a clear, succinct headline that summarizes the key facts. After delivering this news, 'Expect Emotion' and pause to respond with empathic statements. Next, 'Map Values' by eliciting what is most important to the patient/family/surrogate and exploring their goals and preferences. 'Align' with the patient by reflecting their values to demonstrate they are being heard. Then, 'Propose a Plan' using medical judgment to recommend a treatment option that upholds their values and is most likely to lead to an outcome aligned with their goals (table 4).

A second tool is the Best Case/Worst Case framework, which has been shown to improve shared decision-making between surgeons and patients/family members/surrogates.^{12,13} This model

Table 4 REMAP framework for delivering serious news (VitalTalk)

Mnemonic	Component of framework
R	Reframing the situation (assess patient perspective and offer information).
E	Expect emotion (pause to respond with empathic statements).
M	Map values (elicit what is most important to the patient).
A	Align with the patient (reflect their values to demonstrate they are being heard).
P	Propose a plan (recommend treatment that upholds patient values).
Content adapted from VitalTalk. ¹¹	

uses the medical story and a visual aid to illustrate the range of outcomes from best case to worst case framed with and without intervention. The surgeon then uses their judgment to describe what outcome is most likely for the patient. By contextualizing interventions in the setting of overall outcomes rather than focusing on details, it is easier to engage patient/family/surrogates in shared decision-making in complex situations. In practice, both the REMAP and the Best Case/Worst Case frameworks can be used together and should be viewed as synergistic tools for difficult communication. Above all, honest empathy and real connection with patients and their families is most important to the success of difficult conversations.

What is the role of the acute care surgeon in death and dying and how best can acute care surgeons address end of life symptoms such as pain, depression, anxiety, and need for spiritual and psychosocial support?

Recommendation

Acute care surgeons frequently care for patients with an increased risk of dying. Thus, surgeons must be skilled in delivering primary palliative care, including: (1) recognizing life-limiting disease and illness trajectories, (2) alleviating distressing physical and psychosocial symptoms, (3) eliciting patient's goals, priorities, and willingness to make trade-offs to achieve acceptable outcomes, (4) engaging specialists and optimizing communication across care teams, and (5) preserving human dignity and autonomy at the end of life.

Discussion

Acute care surgeons must be able to frame surgery and critical care in the context of a patient's underlying illness (eg, injury, cancer, organ failure) and expected health trajectory. Thus, surgeons must engage specialists when necessary to establish the patient's expected prognosis with and without surgery. Even seemingly small interventions may pose challenging recoveries associated with discharge to an institution and life-altering complications.

Interviews with patients after emergency surgery reveal that they were willing to undergo major high-risk surgery to rid themselves of extreme pain and anxiety.¹⁴ Thus, alleviating pain, nausea, anxiety, thirst, and spiritual distress is often necessary before patients and families can meaningfully discuss treatments. In the intensive care unit (ICU), addressing and avoiding symptoms includes preserving physical and cognitive function and thinking of the family as a unit of care to address the patient's full psychosocial needs.

If the patient is too ill or unwilling to withstand surgery and ensuing critical care or ongoing outpatient care, conversations individualized to each patient should include palliative options in the context of the patient's condition. This requires keen judgment from the acute care surgeon to avoid proceeding with surgical intervention when the best possible surgical result will not yield an outcome acceptable to the patient. Surgeons must use evidence-based communication strategies to facilitate shared decision-making compassionately and effectively.

Acute care surgeons should be comfortable consulting specialty palliative care early in the patient's course in a manner that is transparent to the patient, family, and care team. Specialty palliative care is appropriate when there is conflict within the team, refractory physical or psychosocial symptoms, and to facilitate complex transitions of care.¹⁵ A hospital system that has early palliative care consultation based on triggers can facilitate the

provision of excellent care and decrease the number of procedures and length of stay without impacting survival.¹⁶

When patients cannot survive outside an acute setting or they decline life-sustaining treatments (eg, transfusions, dialysis), the acute care surgeon should assure the patient's comfort and dignity, transfer to hospice as appropriate, and ensure physical and emotional support for the patient's family and caregivers.¹⁷

What are the components of goals of care conversations and when is the optimal timing for these discussions?

Recommendation

Goals of care (GOC) conversations should serve to clarify treatment options that most closely align with the goals, values, and preferences of the patient in the context of a specific medical diagnosis and prognosis. Family and surrogate decision-makers should be engaged in GOC conversations when appropriate. Preferences around intubation, attempting resuscitation in the event of cardiac arrest, and use of life-sustaining medical therapies should be discussed, with careful attention to expected benefits and burdens of interventions. GOC should be clarified with the patient or surrogate ideally within 24 hours of admission, before operative intervention whenever possible, and no later than 72 hours after admission. GOC should be revisited frequently as both goals and clinical circumstances may change throughout the hospital course.

Discussion

GOC conversations should generally be used to clarify all or some of the following components: medical diagnosis and prognosis if known, potential options for treatment (including time-limited trials, palliation, and comfort care where appropriate), and patient perspectives and preferences.¹⁸ The patient should participate in GOC conversations when able. Family and surrogates should be reminded to practice substituted judgment by making the decision that they think the patient would make for themselves. Understanding and explicitly discussing the patient's goals, hopes, and fears is critical to ensure the care plan aligns with the patient's values. Recognizing the patient's views concerning impaired functional outcome, quality of life, and trade-offs in function is helpful. Preferences should be discussed regarding the use of intubation, resuscitation in the event of cardiac arrest, and the use of life-sustaining medical therapies such as dialysis, artificial hydration/nutrition, and tracheostomy with mechanical ventilation.

In the acute care surgical setting, three common constraints often apply when establishing GOC.¹⁹ First, the time-sensitive nature of trauma and acute surgical conditions may necessitate rapid decisions without complete understanding of diagnosis, prognosis, and patient values. Second, patients may lack capacity due to the acuity of illness, prompting the need to identify and engage a surrogate. Third, acute care surgeons usually have no pre-existing relationship with the patient and therefore lack foundational knowledge of the patient's preferences. Despite these challenges, acute care surgeons should make routine efforts to clarify GOC whenever possible, because doing so results in higher value care, improves quality of care, and reduces non-beneficial care and costs.^{20 21}

The optimal timing for GOC conversations is ideally within 24 hours, before operative intervention, and no later than 72 hours after hospital admission.¹ These conversations should not be deferred until clinical deterioration or imminent death. Acute care surgeons should be prepared to conduct conversations early in the hospital course, and certainly before proceeding with

operative intervention when risk of morbidity and mortality is high. For critically ill patients, any member of the ICU team trained to provide primary palliative care may ensure timely GOC conversations within the first 24 hours of admission.¹⁶ GOC clarification should be considered an iterative process as goals may change and should be revisited throughout the hospitalization and with changes in medical condition. It is also necessary to compassionately communicate updates in clinical status to avoid non-beneficial interventions in dynamic clinical environments.

What is the preferred approach to establishing code status and what is the role of ACP documents?

Recommendation

Code status is a medical order and should be established at hospital admission by having a collaborative conversation with the patient and/or their surrogate. Though not an official medical order, ACP documents may be helpful in guiding difficult conversations and ensuring that the patient's wishes are respected throughout hospitalization.

Discussion

The preferred approach to establishing code status in the acute care surgery patient is to have a proactive and collaborative conversation with the patient and/or their surrogate as early as possible in the admission process. This conversation should aim to elicit the patient's goals, values, and preferences for their care, as well as to provide information about the benefits, risks, and alternatives of potential interventions.²²

Code status refers to the level of medical intervention a patient wishes to receive in a life-threatening emergency, such as cardiac arrest or respiratory failure. Code status can range from 'full code' (all measures taken to resuscitate the patient) to 'do not attempt resuscitation' (also known as 'do not resuscitate' or DNR). Variants include 'do not intubate' and 'comfort care only' which, respectively, refer to avoiding intubation and mechanical ventilation in the event of respiratory decline and exclusive use of palliative treatments directed at easing pain and suffering. The goal of the code status conversation is to reach a consensus on the most appropriate resuscitation approach for the patient based on their goals and priorities. Establishing code status through shared decision-making can improve the quality of care and respect for the patient's dignity and autonomy. Code status should be documented in the medical record and communicated to all relevant parties. Required clarification of code status orders is necessary prior to operative intervention. While numerous organizations including the ACS, American Society of Anesthesiologists, and Association of Operating Room Nurses have issued official policies against automatic suspension of DNR orders, many clinicians incorrectly assume automatic suspension is appropriate or even mandatory.^{23 24} However, a patient may proceed to the operating room and maintain code status preferences including no attempt at resuscitation in the event of cardiac arrest.

Though not an official medical order, ACP documents are helpful in guiding difficult conversations. ACP documents are written statements that express the patient's values, goals, and wishes for future healthcare. ACP documents should address the patient's preferences regarding cardiopulmonary resuscitation, intubation, mechanical ventilation, artificial nutrition and hydration, renal replacement, blood transfusions, and other interventions. Advanced directives are legal documents that specify the

patient's treatment preferences and designate a surrogate if a patient is unable to make decisions.²⁵

Unfortunately, ACP documents are not always available, accurate, or applicable. Therefore, the overarching approach to care planning and code status is to support shared decision-making between the patient (when possible) and the treatment team.²⁶ The conversation should explore the patient's understanding of their condition and prognosis, expectations and concerns, values and preferences for end of life care, and willingness to accept or decline life-sustaining interventions. With effective shared decision-making, patients can avoid unwanted interventions and ensure that care is consistent with their values.

When and why should specialty palliative care services be involved in the care of acute care surgical patients?

Recommendation

Specialty palliative care should be involved in the care of trauma and emergency general surgery patients when needs and care transitions are complex, including patients with advanced malignancy or organ failure, refractory pain, or when there is conflict among treating physicians and/or family members. Geriatric patients with severe or disabling injuries or critical surgical conditions should be considered for specialty palliative care consultation when feasible to reduce length of stay and increase rates of goal-concordant care.

Discussion

Primary palliative care is incorporation of palliative care skills and principles performed by the primary team caring for the patient. Specialty palliative care is provided by an interprofessional team of consultants. Specialty palliative care services and resources may be limited in some settings, highlighting the critical importance of primary palliative care and the need to recognize which patients may benefit most from specialty palliative care when available.

Acute care surgical patients with advanced malignancy, organ failure, refractory pain, and challenging or difficult to manage symptoms may benefit from specialty palliative care services. Conflict among treating physicians and/or family members as well as patients with complex care transitions may also be more effectively addressed through engagement of specialty palliative care services. Acute care surgeons serving as intensivists in the ICU may face challenges when providing primary palliative care to patients who have undergone surgery with another surgical discipline, particularly if there is disagreement around the appropriateness of palliative care. In these situations, specialty palliative care may be appropriate to help navigate conflicts among multidisciplinary teams and to ensure care plans are aligned with the goals and values of the patient.

Injured patients aged 65 years and older may specifically benefit from early specialty palliative care services. Palliative care utilization is higher for older trauma patients who die in the hospital; however, older patients with poor outcomes often are discharged without palliative care involvement.²⁷ Specialty palliative care in geriatric trauma patients is associated with higher rates of discharge to hospice, lower intensity end of life care, reduced hospital and ICU length of stay, and decreased odds of rehospitalization.^{28 29} Further, early specialty palliative care consultation has the strongest impact on improved outcomes.³⁰ Geriatric trauma patients who receive early palliative care consultation are less likely to undergo tracheostomy and percutaneous endoscopic gastrostomy (PEG) and are more likely to survive 1 year post trauma than patients who undergo tracheostomy/PEG.³¹ There is clearly a benefit to early specialty palliative care

Table 5 Components of capacity—CURA mnemonic

Mnemonic	Components of capacity
C	Communicate a clear choice.
U	Understand information regarding diagnosis and treatment options.
R	Reason around the proposed treatment choices.
A	Appreciate the risks, benefits, and burdens of the treatment choice.

involvement for geriatric trauma patients for improved patient-centered outcomes.

How and by whom is capacity determined and when should surrogates be sought?

Recommendation

Capacity may be evaluated by a licensed clinician with an understanding of the capacity criteria and the patient's condition, although local laws and/or institutional protocols may provide further specifications. Capacity may be determined with a structured criteria evaluation (eg, CURA mnemonic) or with an assessment tool (eg, Aid to Capacity Evaluation). A surrogate should be sought if the patient lacks capacity and does not have a preidentified decision-maker.

Discussion

Capacity is the ability for a person to make informed decisions in the medical setting. Unlike the legal determination of competence, capacity can vary with circumstances and can be limited to specific aspects of decision-making.^{32,33} Capacity centers around four functional factors (CURA mnemonic): (1) Communicate a clear choice, (2) Understand information regarding diagnosis and treatment options, (3) Reason around the proposed treatment choices, and (4) Appreciate the risks, benefits, and burdens of the treatment choice³² (table 5). Additional consideration should also be given for psychiatric, cognitive, emotional factors, and personal values. Importantly, while a patient may not have capacity to make all medical decisions, they may still be able to make focused/limited decisions or identify a surrogate.³²

Generally, any licensed clinician may evaluate and determine medical capacity. Local laws and/or institutional protocols may provide further specifications. To appropriately assess the patient's understanding, this clinician must be familiar with the patient's mental and medical status and implications of the proposed treatment.³⁴ There may be wide variability in determining capacity based on the clinician's specialty training.³⁵ A structured evaluation that addresses the previously mentioned criteria for capacity should be used for the initial assessment.³⁶ The Aid to Capacity Evaluation is also commonly used with relatively high inter-rater and test-retest reliability.^{34,37} In cases where there is uncertainty regarding capacity, it is reasonable to request an evaluation by a clinician who routinely completes capacity evaluations.³⁴

In instances where a patient lacks capacity, a surrogate is necessary. In cases where a healthcare power of attorney or living will is available, statutory framework often predefines capacity and identifies a surrogate. If no predetermined surrogate can be identified, next of kin may provide consent in most states. If a patient has no surrogate, many states have laws that allow for unilateral decision-making by the clinician for minimally invasive and routine treatment. Two physicians should independently assess the patient and the options before any major medical decision, such as those related to withholding life-sustaining treatment or any decision requiring anesthesia, and care should be provided

in accordance with organizational protocols and state or federal regulations.³⁸

What is the role of procedures and surgery in patients who have comfort-focused goals or are not pursuing disease-directed therapies?

Recommendation

In patients with comfort-focused goals or who are not pursuing disease-directed therapies, procedures and surgery should be carefully considered based on individual preferences, quality of life impact, and potential for symptom management.

Discussion

In patients prioritizing comfort-focused goals over disease-directed therapies, decision-making regarding procedures and surgery necessitates careful consideration of individual preferences, quality of life impact, and potential symptom management. Comfort-focused care aims to enhance well-being and alleviate distressing symptoms, sometimes through procedural interventions (eg, paracentesis to relieve ascites or thoracentesis for pleural effusions) or surgery (eg, gastrostomy tube, stoma creation, or bypass for gastrointestinal obstruction).³⁹ These procedures may provide symptomatic relief, improve function, and enhance overall comfort, thereby contributing to the patient's quality of life. Similarly, interventions like nerve blocks or palliative radiation can effectively mitigate pain and improve overall quality of life in those with advanced illnesses.⁴⁰ Palliative radiation aims to shrink tumors or alleviate symptoms such as pain, bleeding, or obstruction, thus enhancing comfort.⁴¹

However, the decision to pursue these treatments should involve shared decision-making and a thorough assessment of the patient's values, preferences, and goals, emphasizing open communication.³⁹ While some procedures may significantly enhance quality of life, careful evaluation of their potential benefits and risks in the context of the patient's prognosis is essential to ensure alignment with comfort-focused care principles. This approach underscores the importance of interdisciplinary collaboration and patient-centered care to optimize outcomes. A holistic approach that addresses physical, psychological, social, and spiritual aspects of care may be used to promote comfort.^{42,43} By prioritizing open communication and patient-centered care, clinicians can optimize outcomes and enhance the quality of life for patients.

How should the acute care surgeon respond when asked to perform an operation that they consider harmful or non-beneficial, unlikely to achieve the patient's goals, or unlikely to change the trajectory of illness?

Recommendation

A standardized structural communication framework should be used to ensure that patients receive care that is aligned with their values and goals while avoiding non-beneficial surgery. Surgeons should recommend treatment options that align with the patient's values and goals. Patients and families expect surgeons to use their clinical experience and knowledge when making recommendations and to compassionately communicate when they deem a treatment option to be harmful or non-beneficial.

Discussion

Acute care surgeons occasionally find themselves in a scenario where performing an operation is not likely to be beneficial or improve outcome. Limiting or withholding non-beneficial treatment is ethically responsible in theory. However, in

practice, setting external limits on treatment can be very challenging. Indeed, factors associated with the provision of non-beneficial surgery are often outside of the surgeon's control. In a national survey, more than a third of respondents would offer surgery to a seriously ill patient with an acute surgical problem, even if the surgical intervention was unlikely to provide benefit.⁴⁴ Once an acute surgical diagnosis is made, the entire system may be primed to provide further treatment leading toward a surgical intervention, a phenomenon that has been termed 'clinical momentum'.^{44 45} Surgeons may find it difficult to 'stop the line' once sufficient momentum has occurred. In these instances, providing a reframing strategy to communicate to patients/surrogates a framework that promotes shared decision-making is helpful.⁴⁴ Surgical discussions often center around the surgical disease as an isolated problem ('fix it' model) which may be misleading in patients with significant comorbidities.^{44 45} An interdisciplinary panel has published recommendations for surgeons regarding best communication practices to facilitate goal-concordant care for seriously ill older patients with emergency surgical conditions.⁴⁶ This framework centers on a discussion describing the acute surgical problem as it relates to the patient's underlying illness and prognosis, incorporating the patient's personal goals and priorities, and culminating in disclosing both surgical as well as non-surgical and palliative treatment options.⁴⁶

A standardized structural communication framework is crucial to ensure that patients receive care that is aligned with their values and goals while avoiding non-beneficial surgery.^{13 46} One aspect of this communication process requiring further study is the role of the surgeon's opinion and their presentation of treatment options, as well as the heterogeneity in which it may be provided to patients or their surrogates. The presented treatment options can often be on a spectrum ranging from (1) no choice, where surgery is not offered or where surgery is presented as the only option; (2) a biased choice, where the communication is framed for the decision to favor a particular treatment strategy; or (3) a simple choice, where the patient or surrogate is presented with options and the surgeon does not provide a recommendation.⁴⁵ Indeed, offering surgery as an option may suggest that the surgeon thinks it is a high-risk but reasonable option rather than non-beneficial.⁴⁴ Surgeons should convey their professional assessment and recommendation, thereby providing context and transparency.⁴⁷ This recommendation provides the patient and their surrogate the benefit of the surgeon's expertise rather than burdening them with the sole responsibility for a decision. Surgeons have specialized clinical experience and knowledge that patients and their surrogates expect surgeons to use in deliberating and communicating a treatment recommendation.⁴⁸

Surgeons may find themselves in a situation where a patient or family is asking the surgeon to provide treatment that the surgeon deems harmful or non-beneficial. Surgeons are not ethically or legally obligated to offer treatments that will not benefit the patient, even if the patient or family do not agree with their assessment. Many healthcare systems have policies to help address this conflict, often with input from a hospital ethics committee. Specialty palliative care services may also be engaged to provide support to both the surgical team and the patient and their family.

How should palliative care be incorporated into surgical training programs and healthcare systems?

Recommendation

Primary palliative care principles should be introduced during surgical training programs through trainee exposure, courses, and rotations. Care systems should incorporate screening for palliative care needs early in the hospital course and triggers may be used for specialty palliative care involvement. Purely consultative approaches will lead to underutilization.

Discussion

The need to introduce palliative care during surgical residency training has been recognized, especially given feedback from trainees regarding their unpreparedness for participation in difficult conversations.^{49–54} A variety of models such as self-learning via texts and online modules are available from different sources, including those from the American Board of Surgery, the ACS, and surgical council (SCORE).^{49 51 52 55 56} The Palliative Surgical Care course offered by the ACS or those courses specifically developed for incorporation in residency programs may be useful.^{49 51 52} Others have developed a palliative care curriculum with simulation and rotations.⁵⁵ Alternatively, case-based practice may be obtained during rotations where palliative care is often used, such as the ICU or even in outpatient clinics.⁵⁴ Finally, specialty training for surgeons via fellowship training in hospice and palliative medicine is available.⁵⁷

The WHO has recommended integrating palliative care as a core component of healthcare systems.⁵⁸ Since specialty palliative care may be a limited resource in many settings, acute care surgeons should be prepared to provide primary palliative care.⁵³ There are a variety of models for integration of palliative care, including: (1) palliative care screening and assessment; (2) delivery of primary palliative care by the surgical team; and (3) consultative specialty palliative care.⁵⁹ Although infrequent, integrated palliative care provided by surgeons board certified in palliative care does also occur.⁵⁹ With regard to ICU patients, models include an integrative model whereby palliative care principles are part of the daily ICU care of critically ill patients; a consultative model, whereby palliative care consultation is only sought in patients at elevated risk of adverse outcomes; and a hybrid trigger-based consultative approach.⁶⁰ A single question (Does the patient have any palliative care needs?) may be integrated into daily trauma ICU rounding.⁶¹ Consultative methods are commonly used but often have limited utilization in surgical patients.⁶² Various palliative care triggers in the ICU such as unplanned readmission and advanced/metastatic cancer have been associated with discharge to hospice or in-hospital mortality.^{63 64} ICU patients may simultaneously receive curative treatments as well as palliative interventions according to patient and family preferences.⁶⁰

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