

Robert Wood Johnson Foundation Office of Promoting Excellence in End-of-Life Care: Executive Summary of the Report from the Field

Surgeons Palliative Care Workgroup

I. BACKGROUND AND CONVENING PROCESS

In recognition of a growing interest in palliative care by clinicians, patients, and families, the Promoting Excellence in End-of-Life Care national program of The Robert Wood Johnson Foundation, in conjunction with the American College of Surgeons, created a national Peer Workgroup to facilitate introduction of the precepts and techniques of palliative care to surgical practice and education in the United States and Canada. The World Health Organization has defined palliative care as “The active total care of patients whose disease is not responsive to curative treatment.”¹

The Surgeons Palliative Care Workgroup brought together surgeons with demonstrated interest and experience in palliative care to share resources, strategies, and expertise, and in so doing act as a catalyst for change. This is a summary of their analysis of the current state of palliative care in the surgical field and their recommendations. The full report will be released this summer by the Robert Wood Johnson Foundation.

The Workgroup met during a 14-month period from September 2001 through November 2002. The initial Workgroup membership of 20 consisted of 17 surgeons representing 6 subspecialties, representatives of the executive and administrative staff of the American College of Surgeons, two recognized leaders in palliative care research and education, and a representative of the National Program Office of the Robert Wood Johnson Foundation.

The Workgroup divided into seven subcommittees and conducted its business at four plenary sessions and periodic teleconferences. The Workgroup adopted the American College of Surgeons' *Statement of Principles*

Guiding Care at End of Life (1998)² as its compass in the execution of its charge.

After approval by the American College of Surgeons Board of Regents in October 2002, the Workgroup became integrated into the Division of Education of the American College of Surgeons as the Surgical Palliative Care Task Force.

II. CLINICAL SKILLS—CORE COMPETENCIES

The Workgroup identified the following core competencies in surgical palliative care for the practicing surgeon.

A. Patient care

1. Possess the capacity to guide the transition from curative and palliative goals of treatment to palliative goals alone based on patient information and preferences, scientific and outcomes evidence, and sound clinical judgment.
2. Perform an assessment and gather essential clinical information about symptoms, pain, and suffering.
3. Perform palliative procedures competently and with sound judgment to meet patient goals of care at the end of life.
4. Provide management of pain and other symptoms to alleviate suffering.
5. Communicate bad news and poor prognoses effectively and compassionately.
6. Conduct a patient and family meeting regarding advance directives and end-of-life decisions.
7. Exercise sound clinical judgment and skill in the withdrawal and withholding of life support.

B. Medical knowledge

Surgeons should acquire knowledge in the fundamentals of palliative care domains as they apply to the breadth of surgical patients. This includes:

1. Acute and chronic pain management
2. Nonpain symptom management
3. Ethical and legal basis for advance directives, informed consent, withdrawal and withholding of life support, and the concept of futility
4. Grief and bereavement in surgical illness

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Members of the Surgeons Palliative Care Workgroup are listed in the Appendix.

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5. Quality-of-life outcomes measurement and prognostication
 6. Role of spirituality at the end of life
- C. Practice-based learning and improvement
1. Recognize quality of life and quality of death and dying outcomes as important components of the morbidity and mortality review process.
 2. Understand their measurement and integration into the peer review process and quality improvement of practice.
 3. Be skilled in the use of introspection and self-monitoring for practice improvement.
- D. Interpersonal and communication skills
1. Be competent and compassionate communicators with patients, families, and other health-care providers.
 2. Be skilled in communicating bad news, prognosis, and redefining hope in the context of cultural diversity.
 3. Develop capacity to function as a leader member of an interdisciplinary team.
 4. Maintain collegial relationships with other health-care providers.
- E. Professionalism
1. Maintain professional commitment to ethical and empathic care that is patient focused, with equal attention to relief of suffering alongside curative therapy.
 2. Show respect and compassion for cultural diversity, gender, and disability.
 3. Maintain ethical standards in the withholding and withdrawal of life support.
- F. Systems-based practice
1. Be aware and informed of the multiple components of the health-care system that provide palliative and end-of-life care.
 2. Be knowledgeable and willing to refer patients to hospice, palliative care consultation, pain management, pastoral care, social services, etc.
 3. Understand resource utilization and reimbursement issues.

III. EDUCATION

The educational activities of the Workgroup had two intended audiences: practicing surgeons and surgical residents. For the practicing surgeon, these activities included: symposia held at the 2001 and 2002 Clinical Congresses and at the 2002 and 2003 Spring Meetings of the American College of Surgeons; a series of articles published in the *Journal of the American College of Surgeons* including CME questions; information presented on the Web site of the American College of Surgeons's

Surgical Palliative Care Task Force, <http://facs.org/palliativecare/index.html>; and questions proposed for incorporation in the Surgical Education and Self-Assessment Program, 2002 to 2004 (SESAP 12). A national conference on surgical palliative care to be jointly sponsored by the College and a surgical center is in the planning stages. To guide future educational efforts, the Workgroup will conduct a needs assessment of the College Fellowship.

Residency education was promoted by the Workgroup's participation in the End-of-Life Education Project for Postgraduate Training Programs, another Robert Wood Johnson Foundation-funded initiative (David Weissman, MD, Principal Investigator). A total of 24 programs have begun the program and an additional 10 are signed up for the future. Feedback from participants has been overwhelmingly positive.

IV. POTENTIAL AREAS OF CLINICAL RESEARCH IN PALLIATIVE SURGICAL CARE

The Workgroup compiled a research agenda based on its review of current clinical practice and its experience in palliative care education.

- A. Surgical decision making
1. Prognostication and the natural history of disease
 2. Selection of ideal treatment modality
 3. Validated outcomes measures for surgical care
 4. Assessment of new procedures
- B. Patient decision making
1. The basis of patient preferences
 2. Demands for care
 3. Informed consent
 4. Decision aids
 5. Family and surrogate decision making
 6. End-of-life decision making
 7. Advance directives and do not resuscitate (DNR) orders
 8. Withdrawal of support
- C. End of Life
- D. Symptom management
1. Pain
 2. Nonpain symptoms
- E. Communication
1. Breaking bad news
 2. Cross-cultural aspects
 3. Family and caregivers
 4. Inter- and intradisciplinary team communication

- F. Processes of care
 1. Models of care
 2. Cost effectiveness
 3. Suffering among health-care professionals
- G. Surgical education about palliative care
 1. Medical students, residency, practicing clinicians
 2. Comparison of training modalities
- H. Methodologic issues for clinical surgical research in palliative care
 1. Assessment of outcomes
 2. Trial designs
 3. Ethics

V. THE FUTURE OF SURGICAL PALLIATIVE CARE

Although in its narrowest definition palliative care pertains to addressing the total needs of the terminally ill patient, there is no reason that as a philosophy of care it should not extend well beyond the boundaries of care for the terminally ill surgical patient, and, ultimately, transform most aspects of surgical practice. The immediate concerns of this report, as outlined above, relate to dissemination of information about basic palliative care, both knowledge and skills, to practicing surgeons, and to those receiving postgraduate training in surgery with a focus on care of the terminally ill surgical patient.

Once such principles have been integrated within the practice, education, and culture of the surgical disciplines, surgeons will be fully prepared to fulfill the time-honored aphorism that lies at the heart of our profession:

To cure sometimes
 To relieve often
 To comfort always.

VI. RECOMMENDATIONS

- A. Needs assessment
 1. Further needs assessment of both the surgeon in practice and surgeon in training is required to develop targeted educational efforts and systems-based changes in surgical palliative care.
 2. Needs assessment of the practicing surgeon through the ACS Fellowship regarding knowledge and attitudes of surgical palliative care
 3. Needs assessment of surgeons to identify barriers to effective palliative and end-of-life care
- B. Education
 1. Develop "Advance Palliative Life Support Course," modification of AMA's EPEC (Education for Physicians on End-of-Life Care) program for surgeons in practice.
 2. Recruit more than 50% surgical residency programs to the End-of-Life Education Project for Postgraduate Training Programs.
 3. American College of Surgeons-sponsored national conference on surgical palliative care
 4. Develop and legitimize surgical palliative care as an academic discipline and subspecialty within the specialties of surgery and palliative care.
 5. Include surgical palliative care as a concept and practice in surgical textbooks and palliative care literature.
 6. Continue to encourage submission of surgical palliative care articles and reports for publication in surgical and palliative care literature.
 7. Add palliative care questions on surgical board examinations, SESAP, and ABSITE exams.
 8. Write an ACS consensus statement defining surgical palliative care and "palliative" in surgical procedures and practice to establish uniformity in research and outcomes language.
 9. Incorporate a palliative care "Speaker's Bureau" as one of the services provided by the Education Committee of the ACS.
 10. Create palliative care visiting professorships, sponsored by the ACS, matching qualified individuals with surgical training programs.
- C. Develop research agenda in surgical palliative care
 1. Establish funding sources and opportunities for surgical palliative care research.
 2. Establish research fellowship/scholars program for surgeons in training and junior faculty in surgical palliative care.
 3. Write a consensus statement on research agenda in surgical palliative care, identifying critical areas for research development such as quality-of-life outcomes, decision making, pain and symptom management, communication, etc.
- D. Liaisons between national and international organizations in surgery and palliative care
 1. Representation of Taskforce members to the ACS Commission on Cancer and Committee on Trauma (COT)
 2. Liaison with other disciplines: nursing organizations, hospice

3. Liaison with international surgical organizations: Royal College of Surgeons, etc
4. Liaison with palliative care societies

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