

## **END-OF-LIFE ISSUES**

When surgeons and the health professionals on the surgical service interact with patients who appear to be approaching a situation that could involve end-of-life decisions, interpersonal and communication skills along with emotional intelligence are essential. Conversations requiring sensitivity and a thoughtful choice of words occur with the patient and, with the competent patient's consent, their families or others with authorized decision-making authority. These discussions should convey the facts in an honest and clearly understandable manner that offers an opportunity for dialogue and does not eliminate hope or offer unrealistic optimism. For young children or adults lacking decisional capabilities, the decision-making power resides in parents or guardians. If there is a language barrier, trained translators should be employed in order to facilitate legitimate communication. Using family members as translators violates best practice except in emergency situations.

While end-of-life decisions frequently bring to mind the elderly patient with several comorbidities or the severely-injured trauma victim, end-of-life decisions involve patients of all ages from the neonatal unit and pediatric oncology wards to all surgical services, with issues ranging from birth anomalies, trauma, cancer, kidney disease, and even iatrogenic events on the wards or in the operating room. Each patient is unique. The surgeon and team need to be aware of psychological, social, cultural, ethnic, religious, spiritual, and even legal issues that may arise (1).

### **Cultural, Religious, and Social Aspects**

Factors influencing the decision to transition from aggressive, potentially curative care to palliative care (supportive care, comfort measures, pain control, non-abandonment, non-curative care) include religious beliefs, cultural traditions, and emotional relationships. The Joint Commission that accredits U.S. hospitals states: "Cultural, religious, or spiritual beliefs can affect a patient's or family's perception of illness and how they approach treatment" and recommends that staff should acknowledge and address these beliefs (2).

A number of studies including those of Shinall and colleagues at Vanderbilt reveal that a high level of religious conviction or devotion equates to insistence on continued aggressive medical intervention when medical professionals would counsel transition to comfort care (3, 4). The surgeon may feel pressured to perform a procedure or continue intervention against their better judgment. The surgeon might suggest a second opinion from a trusted colleague when dealing with families who disagree with a recommended course of action. When religious convictions are involved, offering to invite a clergy person who shares religious values with the patient and family might help with the discussion, but may not change family convictions. When ethnic or cultural values seem to be factors, suggesting that some respected member of their community be involved is acceptable if the decision-makers feel that might be helpful.

Brain death and cardiac death have medical definitions, but brain death remains an elusive target from a religious standpoint (5, 6).

Organ donation questions surface in any end-of-life discussion that relates to trauma victims that might have viable organs. These questions are often addressed through the organ procurement service of each institution, and students should familiarize themselves with their institutional and state policy.

### **End-Of-Life Directives**

The starting point for end-of-life discussions and decision-making should be the clinic visit and the initial dialogue with the surgeon, or even earlier, with the primary care provider. Advanced

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directives are documented instructions describing the wishes of a person concerning extreme methods of treatment in life-threatening situations such as post-operation or trauma. The two most common forms of advanced directives are a living will (document that specifies what life-prolonging medical interventions are permitted if the person is physically or mentally unable to express their wishes) and durable power of attorney (allowing a designated person to assume the right for decision-making when a person becomes physically or mentally incapacitated). These are legal documents that must be signed by the patient and some states require witnessing and notarization (7). Even if an advanced directive exists, it must be made known to the surgeon or other involved health professional. The surgeon or nurse or health professional should inquire about advanced directives and also about the patient's wishes if a situation arises that requires a decision regarding whether or not to initiate certain treatments such as intubation, extubation, mechanical ventilation, discontinuance of vasopressors, etc. Unfortunately, some studies report that this communication does not always happen which can lead to confusion (8).

In the absence of advanced directives, the lucid patient can be asked about their preferences in the preoperative setting. When the patient does not have decisional capacity, the next of kin, such as spouse or adult child, can offer an opinion. In some states, a close friend or even the attending physician may be consulted if there is no family or designated surrogate.

Most medical centers provide services and/or access to social workers, counselors, biomedical ethicists, specialists in palliative medicine, chaplains, and faith-appropriate clergy. The palliative care team offers invaluable assistance to the surgery team with expertise in evaluations and pain management. The surgical team must be aware of these services and consider or request consults as they will not automatically appear. These professionals can provide support and information as well as education to the patient, family members, or others in times of difficult decision-making. The American College of Surgeons Statement of Principles of Palliative Care states: "Palliative care aims to relieve physical pain and psychological, social, and spiritual suffering while supporting the patient's treatment goals and respecting the patient's racial, ethnic, religious, and cultural values. Like all good patient care, palliative care is based on the fundamental ethical principles of autonomy, beneficence, non-maleficence, justice, and duty." (9)

The trauma victim is least likely to have advanced directives in an easily accessible format. Even if the victim is lucid or if family members are available, the emotional stress of the situation may make ascertaining the victim's wishes difficult.

### **End-Of-Life Vocabulary**

The vocabulary for end-of-life discussions includes words that may require explanation in the context employed. Palliative care and palliative procedures are not the same. Palliative care seeks to ease symptoms and/or provide pain relief, often with physical, psychosocial, and spiritual support, and is not usually aimed at cure (10). A palliative procedure is usually a surgical procedure that may provide pain relief or some other benefit such as an operation for small intestinal obstruction from a neoplasm or for a perforation caused by a tumor, but is not necessarily curative (11).

In situations wherein there is agreement that a cure is not likely, a transition to comfort care may occur. Using the phrase "withdrawal of care" is highly discouraged because this transition is not withdrawal of care; the patient will continue to receive care where the aim is symptom relief rather than cure. One type of comfort care is hospice, a philosophy and type of care that provides pain relief and often psychological and spiritual support for persons unlikely to live more than 6 months. Hospice care can take place in a home, a hospital, or a hospice facility; hospice care can be arranged for children as well as adults (12, 13).

**Legal Aspects**

End-of-life situations that may exhibit legal aspects include:

1. Iatrogenic life-threatening surgical complication —
  - a. Must immediately inform the patient, family, or others with authority
  - b. Immediately inform the hospital risk management team
2. Surgical-complication death (death within 30 days of an operative procedure)
3. Attending physician as surrogate end-of-life decision-maker — A number of states allow the attending physician to be a surrogate if there is a patient without decisional capability, no available family or close friend, or a designated decision maker (14)
4. Patient part of a couple who are not in a legally-recognized relationship including, in some states, gay and lesbian couples.

**Resource Management**

The financial implications and resource usage during end-of-life care have been studied. Several reports show that aggressive care (sometimes described as “futile” — meaning highly unlikely to lead to improvement) involving extended periods of ICU stays ending in death or readmissions uses valuable hospital resources and increases costs when compared to less aggressive care or to “do not resuscitate” (DNR) requests (15, 16).

**Effects of End-Of-Life Situations on the Surgical Team**

End-of-life situations take an emotional and physical toll on the surgeon and the team members, and wellness matters may arise. Debriefing the team after a prolonged or problematic end-of-life situation may be needed (17). If some of the team exhibit longer-term effects, they may be advised to utilize employee counseling services.

**Questions**

1. Which of the following persons CANNOT be a surrogate if the patient lacks decisional capability?
  - a. The attending physician
  - b. The head nurse
  - c. The youngest daughter
  - d. A spouse
  - e. A sibling
2. An example of an advanced directive is:
  - a. Promissory note
  - b. Living will
  - c. Policy regarding end of life care
  - d. Surgeon’s operative note
  - e. Do not resuscitate order
3. Hospice care is appropriate for:
  - a. A 50-year-old man with prostate cancer given about a year to live
  - b. A two-year-old child with leukemia who is likely to survive
  - c. A trauma victim with a head injury that might live 2-4 weeks
  - d. A 78-year-old Alzheimer’s patient who is likely to survive more than 1 year
  - e. All of the above

**Answers**

1. Which of the following persons CANNOT be a surrogate if the patient lacks decisional capability?
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  - e. A sibling
  
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