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Evaluation & Management of Patients Being Treated with Palliative Intent at the End of Life with Limited Treatment Options

Description of the Activity	Surgical oncologists are expected to evaluate and manage patients with incurable, locally advanced, or metastatic malignancies who may present with signs and symptoms such as intestinal, biliary, or ureteral obstruction; fistulas; ascites; pleural effusions; lymphedema; bleeding, infection; malnutrition; failure to thrive; and pain. This evaluation includes an assessment of the extent of disease, prognosis, and treatment options. The surgical oncologists work as part of a multidisciplinary team that presents surgical and nonsurgical treatment options to patients and their families, implements an evidence-based treatment plan to palliate symptoms, and develops a discharge plan that encompasses the goals of care.
Functions	❖ Nonoperative/Preoperative ➢ Synthesize essential information from the patient's medical records, discussions with treating physicians, history, physical examination, imaging, laboratory tests, and biopsy/pathology to define the diagnosis. ➢ Develop a cost-effective, evidence-based assessment of the further testing indicated to define the extent of disease and prognosis. ➢ Communicate the diagnosis, prognosis, and potential treatment options to the patient/caregiver(s) and consultants. Use shared decision-making to develop a multidisciplinary treatment plan consistent with the patient's goals and beliefs. ➢ Succinctly identify treatment goals that balance prolongation of life and quality of life. Communicate in a compassionate and culturally appropriate manner when de-escalation of care is recommended because of a poor prognosis or based on patient/caregiver goals of care. ➢ Ensure that code status is established and that a health care proxy/surrogate decision-maker is confirmed for patients without decisional capacity. ➢ Identify the pharmacological therapies that may benefit a patient with unresectable disease. ➢ Involve adjunct services, including palliative care, pain management, case management/social work, spiritual care, and psychosocial services. ➢ Identify the eligibility criteria for hospice care, and recognize when to engage hospice services to meet with a patient/caregiver(s). ➢ If a patient is not capable of independent enteral nutrition and hydration, discuss long-term approaches to nutritional support. ➢ Decide when operative intervention or the preferred form of palliation is not indicated based on the extent of disease, functional/nutritional status, or coexisting comorbidities. Communicate this decision to the patient/caregiver(s) and other health care providers so nonoperative measures can be used to palliate symptoms. ➢ Screen patients for and propose clinical trials when appropriate. ➢ Refer to other clinicians for palliative interventions when needed: ▪ Interventional radiology (venting gastrostomy tube, percutaneous biliary drainage, percutaneous nephrostomy, paracentesis/thoracentesis, embolic management for bleeding, nerve block, kyphoplasty) ▪ Gastroenterology (venting gastrostomy, biliary stenting, intestinal stenting, endoscopic management for bleeding) ▪ Radiation oncology (radiation therapy for pain or bleeding) ▪ Urology (ureteral stenting) ▪ Wound care/ostomy therapists (assistance with care for nonhealing wounds/fistulas) ➢ When operative intervention is planned, obtain informed consent with cultural humility.

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- Develop a concise operative plan based on the patient's diagnosis, extent of disease, prognosis, symptoms, functional/nutritional status, and goals of care.
- Describe the indications, risks, benefits, alternative therapies, and potential complications of the planned procedure, and incorporate a discussion of the goals of care. Compassionately explain to the patient/caregiver(s) that procedural or operative intervention is directed at palliating symptoms rather than curative cancer treatment.
- Explain that intraoperative findings may prohibit the safe performance of an intended procedure, resulting in failure of palliation.
- Explain that operative complications can potentially worsen quality of life and shorten life expectancy.
- Ensure patient/caregiver comprehension using applicable language services and audio/visual aids as necessary.
- Ensure that the patient/caregiver(s) can ask questions, and address any expressed concerns, taking patient/caregiver preferences into account.
- Discuss potential limitations in the desire for resuscitation (eg, do-not-resuscitate order) and how this will be addressed in the perioperative period.
- Document the consent discussion.

❖ Intraoperative

- ➢ Manage the perioperative environment, including room setup, equipment check, preprocedural time-out, specimen processing, counts, wound classification, and debriefing functions.
- ➢ Develop a safe anesthetic approach for the clinical situation in collaboration with in-office staff or the anesthesiology team, depending on the environment selected for the procedure. Create and maintain an intraoperative environment that promotes safety and patient-centered care.
- ➢ Position the patient to expose the operative field, taking precautionary measures to prevent iatrogenic injury.
- ➢ Confirm accessibility of necessary equipment. Coordinate with other members of the operating room team to use specialized equipment or procedures.
- ➢ Adapt operative steps based on intraoperative findings.
- ➢ Perform the (in scope) operations required to manage common scenarios encountered in patients with locally advanced or metastatic malignancy when palliation, rather than cure, is the objective.
- ➢ Accurately assess when it is not safe to proceed with the planned procedure.

❖ Postoperative

- ➢ Communicate intraoperative findings and the procedure(s) performed; expected recovery and future treatment needs; outcome expectations; and follow-up to the patient/caregiver(s) and other health care team members.
- ➢ Manage common early and late complications/issues related to palliative procedures.
- ➢ Continue management of ongoing symptoms.
- ➢ Recognize and mitigate patient-specific barriers to care.

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	➢ Continue care in conjunction with other specialties and ancillary services as needed, such as physical therapy, rehabilitation, dietician, palliative care, pain management, enterostomal therapist, and wound care. ➢ If criteria are met, facilitate a referral to hospice services to meet with the patient/caregiver(s) to educate them on the services available and potential transition to hospice. ➢ Coordinate discharge disposition and follow-up.
Scope	❖ In scope ➢ Diagnoses ▪ All patients with the following malignancies being treated with palliative intent: ● Cancer-related pain ● Cancer-related cachexia ● Gastric outlet obstruction ● Gastrointestinal bleeding ● Lymphedema ● Malignant ascites ● Malignant bowel obstruction ● Malignant fistula ● Malignant obstructive jaundice ● Malignant pleural effusion ● Malignant ureteral obstruction ● Malignant wounds ➢ Procedures (Note: Focus on intraoperative and perioperative decision-making—not technical details of each procedure.) ▪ Goals of care and advance care planning meetings with patients/caregiver(s) and other care teams (eg, medical oncology, palliative medicine) ▪ Code status discussion ▪ Incorporation of advance directives and shared decision-making to achieve goal-concordant care ▪ Referral for palliative medicine consultation ▪ Surgical management of: ● Enteral feeding access: laparoscopic, open ● Gastric outlet obstruction: laparoscopic or open, bypass or resection ● Malignant ascites: placement of peritoneal drain, hyperthermic intraperitoneal chemotherapy

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- Malignant bowel obstruction: laparoscopic, open, resection, bypass, diverting ostomy, venting gastrostomy tube placement, lysis of adhesions
- Malignant gastrointestinal bleeding: laparoscopic or open
- Malignant obstructive jaundice: open or laparoscopic, bypass or open
- Malignant wounds

➢ Populations
- All oncology patients being treated with palliative intent
- Patients who lack decisional capacity
  - Identify and engage surrogate decision-makers.

❖ Out of scope

➢ Diagnoses
- Airway compromise
- Central nervous system (CNS)-related symptoms (eg, cord compression, brain metastases)
- Hematuria from bladder or genitourinary neoplasms
- Malignant fractures
- Nonmalignant pain syndromes
- Paraneoplastic syndromes
- Patients receiving treatment with curative intent
- Patients with chronic pain
- Vaginal bleeding

➢ Procedures
- Advanced endoscopic palliative procedures for bleeding or obstruction
- Flap coverage for malignant wounds
- Interventional radiology procedures for bleeding, pain management, or ureteral obstruction
- Malignant fracture stabilization
- Management of complications from gynecologic malignancies
- Neurologic procedures for CNS metastases
- Percutaneous venting gastrostomy tube placement
- Tracheostomy for airway obstruction

➢ Populations
- Patients pursuing standard curative-intent treatment
- Pediatric patients
- Patients at end of life unrelated to malignancy

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	▪ Patients with chronic nonmalignant pain

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1 **<u>Limited Participation</u>** **Demonstrates understanding of information and has very basic skills.** **<u>Framework:</u>** **Performs at the general surgery resident level, lower than expected for a typical residency graduate. Has some experience with simple cases but has been an observer of complex cases.**	• Performs a thorough H&P and review of imaging and pathologic information but needs assistance to obtain a relevant oncologic history and recognize pertinent exam findings as they relate to a patient's advanced cancer diagnosis • Needs assistance to determine the need for additional imaging or testing • Needs prompting to consider nonoperative palliative treatment options and transition to hospice • If operative intervention is planned, demonstrates understanding of the basic elements of informed consent but needs assistance to communicate the unique aspects of palliative interventions to the patient/caregiver(s) lol • Needs prompting to consider the role of a multidisciplinary team in developing a palliative care plan • Needs prompting to identify the key components of the health care system required for the palliative care of patients • Respectfully communicates basic facts about the condition to a patient/caregiver(s) but needs prompting	• Needs prompting to adapt the operative steps of a palliative operation, including possibly aborting the procedure, based on intraop findings • Needs assistance to coordinate with the multidisciplinary team (anesthesia, OR staff) to consider the need for additional health care resources based on the intraop plan • Needs assistance to manage the periop environment, including room setup, equipment check, preprocedural time-out, and communication with anesthesia and OR staff • Creates a basic operative note but omits some important information; may need prompting for timeliness	• Needs prompting to consider health care resources related to the need for hospice referral and patient consent for hospice and other health care services • Needs prompting to appreciate the need to coordinate care with other specialties and ancillary services (PT, rehabilitation, nutrition services, palliative care, enterostomal therapist) within a complex health care system to coordinate length of stay, discharge, and transition of care; needs significant assistance to manage patient-specific and system-level barriers to care • Needs prompting to consider the ethical considerations of a patient requiring palliative or end-of-life care • Demonstrates understanding of intraop findings and the procedures performed but has difficulty communicating these findings to a patient/caregiver(s) and other health care team members • Documents postop care but may omit nuances of progress or minor complications; may choose an inappropriate means of communication (eg, paging for minor details or email for urgent issues)

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	to discuss ethical concerns (eg, decisional capacity) • With prompting, identifies the need to establish a code status/surrogate decision-maker • Records information in a patient's record but may omit some important information or include some extraneous information; may require correction or augmentation of documentation of services; may need prompting for timeliness		
2 **Direct Supervision** **Manages cases at the level of a newly graduated general surgery resident. Manages less complicated cases independently but needs active guidance for complex cases.** **Framework:**	• Obtains a relevant oncologic history and recognizes pertinent exam findings as they relate to a patient's advanced cancer diagnosis; needs assistance to develop a palliative care plan • Orders additional tests to formulate a diagnosis and plan with some direction • Considers nonoperative palliative treatment options and hospice but needs direction to recommend a treatment plan that incorporates the patient's goals • If operative intervention is planned, communicates the elements of an informed consent discussion but omits some	• Recognizes the need to adapt operative steps during a palliative operation, including possibly aborting the procedure, but needs direction on choosing the best procedure • Coordinates with the multidisciplinary team (anesthesia, OR staff) in a straightforward case but needs prompting to consider the need for additional health care resources based on the intraop plan in a complex case • Demonstrates understanding of how to manage the periop environment, including room setup, equipment check, preprocedural time-out, and communication with anesthesia and OR	• Recognizes the need for hospice referral but needs guidance to coordinate the referral and recognize the role of hospice care and patient consent for hospice services in the broader health care system • Accesses basic ancillary services (eg, PT, rehabilitation, nutrition services, palliative care, pain management, wound care, enterostomal therapist) within a complex health care system to coordinate discharge and transition of care in straightforward cases; needs some assistance to execute coordination to address complex patient-specific and system-level barriers to care in straightforward cases

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The learner can manage simple or straightforward cases. **The learner may require guidance in managing multidisciplinary care (eg, planning neoadjuvant treatment or postoperative chemotherapy).** **During surgery, the attending gives active help throughout the case to maintain forward progression.**	elements when documenting the discussion • Considers the role of a multidisciplinary team when developing a palliative care plan but needs some direction to incorporate appropriate specialties and communicate the plan of care to other members of the health care team • Identifies most of the key components of the health care system required for the palliative care of patients • Respectfully communicates basic facts about the condition to a patient/caregiver(s) in a straightforward case but needs assistance in more complex cases (eg, unclear surrogate decision-maker, family and care team conflict) • Recognizes the need to establish a code status/surrogate decision-maker and leads this discussion in a straightforward case • Considers the role of multidisciplinary discussion in the development of a palliative care plan but needs direction to incorporate appropriate specialties • Demonstrates organized diagnostic and therapeutic reasoning through notes in a patient's record; demonstrates timely and	staff, but needs direction to communicate the operative plan • Creates an operative note with a complete description of the procedure	• Recognizes and addresses common ethical considerations of a patient requiring palliative or end-of-life care in straightforward cases (eg, decisional capacity, advance care planning) • Communicates basic intraop findings and the procedures performed to the patient/caregiver(s) and other health care team members but requires assistance when discussing the implications of the findings on the prognosis • Thoroughly documents a patient's postop progression and the presence of any complications within the plan of management

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	efficient use of the EHR to communicate with the health care team		
3 **<u>Indirect Supervision</u>** **Can do a basic operation but will not recognize abnormalities and does not understand the nuances of an advanced case.** **Manages multidisciplinary care of straightforward cases. Seeks assistance in managing complex cases.** **<u>Framework:</u>** **The learner can perform the operation in straightforward circumstances. The attending gives passive help. This help may be given while scrubbed for more complex cases or during check-in for more routine cases.**	• Synthesizes all relevant oncologic history and pertinent exam and imaging findings as they relate to a patient's advanced cancer diagnosis in a common scenario but needs assistance with a more complex case • Develops a cost-effective, evidence-based assessment of further testing but needs assistance to develop a palliative care plan that considers health care system issues (eg, funding, readmissions) • Discusses the need for a code status/surrogate decision-maker with the patient/caregiver(s) in a complex case with assistance • If operative intervention is planned, communicates the elements of an informed consent discussion, including all palliative surgical options, but may need assistance to discuss the potential need to abort the procedure and its impact on palliation • Coordinates with members of a multidisciplinary team when developing a palliative care plan in a routine case but needs assistance to incorporate appropriate specialties and communicate the plan of care to other members of the health care team in a complex case	• Anticipates potential intraop findings in a straightforward case but needs assistance in a complex case • Inconsistently adapts operative steps to achieve palliation; needs guidance on when to abort the procedure • Coordinates with a multidisciplinary team (anesthesia, OR staff) in a complex case with minimal assistance to access additional health care resources based on the intraop plan • Manages the periop environment, including room setup, equipment check, preprocedural time-out, and communication with anesthesia and OR staff in a straightforward case but may need assistance to communicate the operative plan in a complex case • Creates an operative note with a complete description of the procedure, including key intraop findings; documents anatomic or disease variants in a thorough and understandable way	• Independently determines if the patient meets the criteria for hospice care but needs some assistance to determine the wishes of the patient/caregiver(s) and coordinate the appropriate referrals within the context of the broader health care system (eg, insurance) • Accesses ancillary services (eg, PT, rehabilitation, nutrition services, palliative care, pain management, wound care, enterostomal therapist) to palliate ongoing symptoms and improve quality of life within a complex health care system; coordinates discharge and transition of care in complex cases with limited assistance; independently executes coordination to address complex patient-specific and system-level barriers to care in straightforward cases • Recognizes and addresses ethical considerations of a patient requiring palliative or end-of-life care (eg, decisional capacity, advance care planning) and navigates conflicting goals among care teams and patient/caregiver(s)

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	• Works as a member of the multidisciplinary team in the context of a complex health system coordinating the care of patients requiring palliative care but needs assistance to develop a palliative care plan that considers health care system issues (eg, funding, readmissions) • Communicates the diagnosis, prognosis, and potential treatment options to a patient/caregiver(s) and consultants in an ethical and compassionate manner; uses shared decision-making but needs assistance to develop and communicate a multidisciplinary treatment plan that is consistent with a complex patient's goals and beliefs • Concisely integrates all relevant data from outside systems and prior encounters and reports diagnostic and therapeutic reasoning in a patient's record		• Compassionately communicates intraop findings to the patient/caregiver(s) and other health care team members but needs some guidance when discussing the prognosis and future management options • Selects direct (telephone, in-person) and indirect (progress notes, secure text messages) forms of communication based on context and urgency
4 **Practice Ready** **Manages complex disease presentations and performs complex operations independently. Guides a multidisciplinary approach to complex**	• Synthesizes all relevant oncologic history and pertinent exam findings as they relate to a patient's advanced cancer diagnosis and need for palliative intervention • Independently develops a cost-effective, evidence-based assessment, including the need for further testing, to define a palliative care plan that considers health	• Anticipates all potential intraop findings and adapts the operative plan to achieve the best palliative outcome, including the need to abort the procedure • Proactively coordinates with the multidisciplinary team (anesthesia, OR staff) in straightforward and complex cases, reflecting understanding of how the palliative procedure impacts the	• Independently determines if the patient meets the criteria for hospice care and integrates the wishes of the patient/caregiver(s); coordinates the appropriate referrals within the context of the broader health care system (eg, insurance)

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cases. Performs as an expert consultant in surgical oncology. **<u>Framework</u>:** **The learner can treat all common variations of the disease and has a strong understanding of surgical and medical options for different presentations.** **The attending is available at the request of the learner but is not routinely needed for common presentations, though input may be needed for more complex or unusual presentations.**	care system issues (eg, funding, readmissions) • If an operative intervention is planned, communicates the elements of an informed consent discussion, including all palliative surgical options and the potential need to abort the procedure • Proactively coordinates with members of the multidisciplinary team when developing a palliative care plan in routine and complex cases, incorporating appropriate specialties and communicating the plan of care to other members of the health care team • Independently coordinates multidisciplinary care and patient navigation for a patient requiring palliative care in the context of a complex health care system • Communicates the diagnosis, prognosis, and potential treatment options to a patient/caregiver(s) and consultants in an ethical and compassionate manner; in routine and complex cases, uses shared decision-making to develop and communicate a multidisciplinary treatment plan consistent with the patient's goals and beliefs	need to access additional health care resources (eg, wound or ostomy care, skilled nursing) • Independently manages the periop environment, including room setup, equipment check, preprocedural time-out, and communication with anesthesia and OR staff • Creates an operative note with a complete description of the procedure, a rationale for modifications of the operative plan, and documentation of anatomic or disease variants	• Leads and proactively coordinates care with other specialties and ancillary services (PT, rehabilitation, nutrition services, palliative care, pain management, wound care, enterostomal therapist) to palliate ongoing symptoms and improve quality of life within a complex health care system; coordinates discharge and transition of care in complex cases without assistance; independently executes coordination to address complex patient-specific and system-level barriers to care in complex cases • Recognizes and proactively addresses the ethical considerations of a patient requiring palliative or end-of-life care (eg, decisional capacity, advance care planning) and navigates conflicting goals among health care teams and the patient/caregiver(s) in a complex situation • Compassionately communicates intraop findings to a patient/caregiver(s) and other health care team members and conducts an ethical discussion on the prognosis and future management options • Communicates clearly, concisely, promptly, and in organized written

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	• Discusses the need for a code status/surrogate decision-maker with the patient/caregiver(s) in a complex situation without assistance (eg, patient lacking decisional capacity) • Leads a multidisciplinary discussion about developing a palliative care plan, incorporating appropriate specialties • Communicates diagnostic and therapeutic reasoning clearly, concisely, promptly, and in an organized written form, including anticipatory guidance; written or verbal communication (patient notes, email) serves as an example for others to follow		form, including anticipatory guidance so the postop plan of care is clear to other members of the health care team