High-risk seniors surgery decisions should be patient-centered, physician led

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Surgery for frail, senior citizen patients can be risky. A new patient-centered, team-based approach to deciding whether these high-risk patients will benefit from surgery is championed in an April 10 Perspective of the *New England Journal of Medicine*. The Perspective suggests that the decision to have surgery must balance the advantages and disadvantages of surgical and non-surgical treatment as well as the patient's values and goals in a team-based setting that includes the patient, his or her family, the surgeon, the primary care physician and the physician anesthesiologist.

One third of older Americans have surgery in the last 12 months of their lives, most within the last month. Yet, three quarters of seriously ill patients say they would not choose surgery if they knew they would have severe cognitive or functional complications afterward.

Traditionally, the decision to have surgery is made after a discussion between the surgeon and patient and perhaps the patient's spouse, child or caregiver, according to the Perspective. However, this approach may not be best for high-risk senior patients. The Perspective suggests that the decision should be made between the patient and a team of medical experts who can explain each option (surgical and non-surgical), as well as each option's benefits and risks.

"Patient-centered care means that patients make health care decisions in equal partnership with their physicians," said Laurent G. Glance, M.D., professor and vice-chair for research in the department of anesthesiology

at the University of Rochester School of Medicine. "These decisions should be driven by the patient's values and preferences. For some patients, autonomy and quality of life may be much more important than quantity of life."

The Perspective suggests that high-risk senior patients should be given the choice among treatments (including no treatment) and the information they need to understand the potential benefits of each option, the likelihood of a good outcome and the risk of complications.

Dr. Glance acknowledges that this shift to team-based care for this small patient population would increase the cost of medical care, but suggests that this could be mitigated by the use of "virtual" teams. Each team member would have electronic access to the patient's data and the team "discussion" could take place electronically. He predicts that the management of patients in the future will occur in "surgical homes," a concept the American Society of Anesthesiologists® advocates through its Perioperative Surgical Home (PSH) initiative.

ASA® is currently developing a learning collaborative for its PSH model of care. This collaborative of health care organizations will work to improve the care of surgical patients from the moment surgery is planned through recovery, discharge and the first 30 days postoperatively. ASA's PSH is a patient-centered, physician-led, team-based practice model of coordinated care that guides a patient throughout the entire surgical experience.

While some in the medical community may question the effectiveness of team-based care, Dr. Glance suggests that with one out of every 150 hospitalized patients dying from a complication, 40 percent of the complications happening in surgical patients and half of surgical complications being preventable, new approaches need to be explored. "Striving to make surgical decisions more patient-centered and

accountable through team-based approaches seems like a good place to start," he said.

Provided by American Society of Anesthesiologists