For sick, elderly patients, surgical decision making 'takes a village'

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Surgical decision making for sick, elderly patients should be orchestrated by a multidisciplinary team, including the patient, his or her family, the surgeon, primary care physician, nurses and non-clinicians, such as social workers, advocates Laurent G. Glance, M.D., in a perspective piece published in the *New England Journal of Medicine*.

For this group of patients, surgery can be very risky. Glance, professor and vice-chair for research in the Department of Anesthesiology at the University of Rochester School of Medicine and Dentistry believes a more patient-centered, team-based treatment approach would lead to higher quality care that matches the values and preferences of the sickest patients.

Usually, patients undergo a one-on-one consultation with their surgeon, who is frequently solely responsible for most of the decision making and management surrounding a possible surgical procedure. However, this traditional approach has potential pitfalls. For example, patients may not always be presented the full range of treatment options, such as medical treatment, less invasive surgical options, or watchful waiting.

"Evaluating treatment options, formulating recommendations and articulating the benefits and risks to patients comprehensively require more than a well-informed or experienced surgeon," noted Glance, who is also a professor of Public Health Sciences and a cardiac anesthesiologist at UR Medicine's Strong Memorial Hospital, in addition to holding an adjunct appointment at RAND Health.

Consultation with a team of medical personnel, on the other hand, helps patients better understand the benefits and risks of each option, the likelihood of a good outcome and the risks of complications, enabling them to make informed decisions that are driven by what's most important to them and their family.

According to the article, one-third of elderly Americans have surgery in the last 12 months of their lives, most within the last month. But, three-quarters of seriously ill patients say they would not choose surgery if they knew they are likely to have severe cognitive or functional complications afterward.

Currently, such teamwork occurs mostly on an ad hoc basis, says Glance. In the future, multidisciplinary teams could meet regularly – in person or virtually – to discuss high-risk cases. By limiting the focus of such efforts to frail, elderly patients or to those with complex conditions who stand to benefit most from this multidisciplinary approach, healthcare organizations could minimize the costs involved. However, Glance acknowledges that gaining acceptance of this shift in the current culture

of surgical decision making may not be straightforward.

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