

Patient Assessment in Palliative Care: How to See the “Big Picture” and What to Do When “There Is No More We Can Do”

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“It doesn’t look good on CT,” said the radiologist with a resigned look as he finished dictating the results of the films on a 47-year-old man with painless jaundice and weight loss I was asked to see in the emergency room. I thought jaundice was probably the *best* thing he had, given the multiple liver metastases I saw on his CT. The source of his metastases was no mystery judging from the look of the pancreas. “Does this guy have any idea about this,” asked the radiologist. “I don’t really know,” I said, trying to pull together what I really did know about the man. “He’s married with three kids, all still in school. His wife is worrying about the HMO dinging her for an unauthorized ER visit: wait till she learns about this,” I said, sliding the last of his films in the jacket. “Too bad there’s nothing more you can do,” said the radiologist as he continued with his dictations.

I was annoyed with his sentiment, but partly jealous of his detachment from this situation. He was right. There was not much to do in the “usual” sense of controlling disease, but I didn’t know where to start going from here. The relationship this man had with his primary physician was not a good one by his own account, and this gave me an added sense of urgency about helping him any way I could.

Later, as I looked at his needle biopsy through a microscope at the islands of tumor in the darkening sea of liver parenchyma, it occurred to me I needed a different kind of lens to see this person and his circumstances as clearly as the microscope showed me this tiny fragment of the man. This new optic would gather more information about him and make sense of all that was happening and was going to happen to him.

We all have been at this point, and we all have felt the

frustration of not having a satisfying operative solution for a problem that won’t go away. How do we conceptualize these encounters so we can be of service without having to withdraw or refer to someone else, someone who may not have our skills or our patient’s trust? The end of life and dying, itself, are not merely medical events, though it may seem that way in a culture that heavily relies on a pathocentric medical system as the source, means, and purpose of our life. Surgeons are not alone in yielding to the temptation of viewing the end of life as a stage of a disease that must be controlled. How often have we encountered patients and families desperately Internet-searching for “the cure,” or at least a distraction from the fact that the patient is clearly in the last days or hours of life?

To aid in the assessment of the “whole person” and his or her family, the authors of the American Medical Association’s Education for Physicians on End-of-Life Care Curriculum (EPEC)¹ have introduced an assessment screen consisting of nine dimensions (Table 1). This assessment was based on extensive experience with patients with chronic and terminal illnesses, many of them under the care of surgeons at some point in the trajectory of their illness. This particular assessment has the advantage of familiarity to hundreds of physicians and other healthcare professionals who have already taken this course. The EPEC Curriculum is highly recommended to surgeons seeking a comprehensive understanding of the philosophy and techniques of palliative care. In this article the nine areas of patient assessment identified in EPEC are addressed and modified for a surgical audience.

The immediate goal of patient assessment in end-of-life care is to permit the relief of suffering, though an additional goal is the identification of sources of strength that may be helpful during the developmental challenge of life’s completion. A useful assessment for this purpose must reflect the multidimensional nature of the patients’

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Table 1. EPEC's Nine Dimensions of Whole Patient Assessment for Palliative Care

1. Illness/treatment summary
2. Physical
3. Psychological
4. Decision making
5. Communication
6. Social
7. Spiritual
8. Practical
9. Anticipatory planning for death

EPEC, American Medical Association's Education for Physicians on End-of-Life Care.

(and their family's) experience of illness. Each surgeon must find a comfort level in the degree of exploration of the different dimensions, just as each surgeon would pursue different aspects of care to varying degrees after a trauma assessment. With experience and time permitting, the surgeon will find an increased sense of satisfaction with increasing depth of participation in all of the different dimensions. Trauma care has shown how well surgeons can make assessments of complicated situations in an emotionally charged atmosphere. A surgeon can save the life of a head-injured patient by identifying a rapidly expanding intracranial hemorrhage and knowing when to call a neurosurgeon, just as any surgeon can save the quality of life for a dying individual by knowing when to call a chaplain or a radiation oncologist. To paraphrase one exponent of palliative care in critical care settings,² the surgeon should not only be able to save lives, but also "save deaths."

If surgeons sense they are "over their heads" in any of the areas assessed there should be no hesitation in seeking consultation from palliative care specialists and interdisciplinary teams working in specialized environments (critical care, pediatrics). Through the 1990s these resources have rapidly proliferated in major academic and regional medical centers in the United States and Canada. Hospice, the original paradigm of palliative care, is also available for referral in a wide variety of settings for guidance in palliative care at life's end.

PALLIATIVE CARE ASSESSMENT AS A "STAGING PROCEDURE"

Assessment for palliative care can be seen as a "staging procedure" for the dimensions of distress, similar to the approach used to "stage" the extent of disease. Along with the stepwise procedure for giving bad news out-

lined in our previous article³ it should be considered part of the surgeon's cognitive operative repertoire. Following the general guidelines for communication outlined in the Buckman CLASS (context, listening, acknowledge, strategy, summary) protocol,⁴ an assessment for palliative care can take about 20 to 30 minutes depending on the capabilities of the patient, the complexity of the problem, and the experience of the interviewer. Using an assessment with nine dimensions such as EPEC's may seem daunting, though there is a degree of overlap of the dimensions and many opportunities in the interview to address them. The patient's tolerances determine how much can be discussed and what can be deferred. This is not only time well spent from a practical point of view (about the time it takes to wait for some frozen section reports), but it establishes a basis of mutual trust that is therapeutic in itself: "I'm not sure how much this information will help, doctor, but it's nice of you to ask."

This "operation" requires much of the same preparation as any we do with our hands: time, space, and people all have to be prepared. I also ascertain from the patient whom they would like present for the discussion. In elective or nonurgent situations, depending on where the anticipated need for nonphysician expertise is greatest, I will usually ask for the presence of a nurse familiar to the patient or another member of the interdisciplinary team, such as a social worker. Having more than two or three care providers tends to inhibit discussion, and there is rarely enough room to comfortably position more than five or six people. A window, or at least a landscape painting, is helpful to provide visual respite from difficult moments. I leave my beeper with someone else as I would during any other operative procedure.

Most of these patients have little energy reserve, and this should be considered in the scheduling of an interview that can be physically, mentally, and emotionally exhausting for everyone involved. Before an interview begins, inquire about physical comfort and optimize this. In my own practice, I use an index card with a palliative care assessment (Table 1) clipped to the patient's chart or clipboard as I conduct the interview. The card also has sample questions to guide the various assessments.

Illness and treatment review

In reviewing the history of the illness, the surgeon should avoid the temptation of projecting personal feelings about the badness or goodness of an individual's

circumstances. One time a crusty widow scolded me after my overly quick and solicitous response to the news that her husband had recently died unexpectedly: "It was the best thing that ever happened to both of us! What are *you* so sorry about?" We are not there to express sympathy or judgment about the meaning of a patient's experience, but to assist and guide, using our capacity to empathize.

In review of previous illness and treatment, the surgeon should determine appropriateness based on their known effectiveness and patient preference. Was the degree of disclosure to the patient adequate for the patient to weigh the benefits of undergoing a therapy versus declining it? Such a review can put the reviewer in the weighty position of being the "ultimate gate-keeper."

Occasionally during the review of previous illness, the surgeon will discover that a previously offered treatment, including a potentially curative one, was "written off" because of miscommunication or misunderstanding. Mary Baines, writing about the nonoperative management of malignant bowel obstruction, pointed out that operative therapy should not be selected based on the fear of dying a miserable death when effective pharmacologic alternatives exist, but operative therapy should not be withheld because of knowledge of those same remedies.⁵ In some instances, the life-limiting diagnosis may not be the source of the patient's greatest distress. For some, its significance is overshadowed by a long, personal experience with another chronic, incurable illness such as diabetes or alcoholism.

Whenever possible, symptom management is tailored to the underlying etiology and pathophysiology, though a search for this information should never be an excuse for delaying attempts to relieve symptoms. The most dramatic demonstration of this principle known to surgeons is the relief of burn pain while initial assessment and resuscitation is in progress. On the other hand, the relief of symptoms, even in the last stages of life, should not assume that prolongation of life is not desired.

See Table 2 for screening questions for this part of the assessment.

Physical assessment

Control of distressing symptoms is "Job One" in palliative care. Meticulous symptom management based on equally meticulous assessment is the pediment on which everything else stands, whether it's further medical decision making, a successful discharge, or confidence in the

Table 2. Screening Questions and Prompts During the Illness/Treatment Review

Tell me what you know about your illness.
Could you give me an account about your illness and treatment you have had until now?
Tell me what stands out in your memory . . . (about your illness, about treatment to date).
I will review (have reviewed) your medical history in your chart, but I am really interested in hearing about it from your point of view.

surgeon. If overwhelming physical pain is occurring, a patient might agree to anything, whether it is "no treatment" or "any treatment imaginable." Poorly controlled symptoms distract the individual from the more central concerns of family, selfhood, and life's meaning.

Perhaps one of the greatest breakthroughs in clinical care in recent decades has been the acceptance by physicians of a patient's report and self-measurement of symptoms. Who else could really measure a symptom, an inherently subjective phenomenon? In the assessment of symptoms it is critical that the surgeon accept the self-report of the patient's experience even if the etiology is unclear or there is disagreement about the etiology.

Physical assessment in palliative care uses a framework of symptoms and the activities of daily life instead of an organ system or anatomic approach. Organ failure is irrelevant to palliative care intervention if it is not generating symptoms. Organ or system failure may be relevant if the fears of organ failure are generating psychological or spiritual symptoms. Multiple symptoms are present in advanced illness such as cancer⁶ and these are more numerous in an inpatient setting.⁷ The salient symptoms encountered in advanced illness and end of life include weakness and fatigue, pain, breathlessness, anxiety, depression, confusion, constipation, anorexia, insomnia, and nausea and vomiting. In much of the palliative medicine literature, weight loss, edema, jaundice, and bleeding are discussed as symptoms despite the fact that they are, technically, clinical signs. This is partly from their psychological impact on patients and caregivers. Any symptom can be a barrier to satisfaction with life and the ongoing developmental process of life's completion.

It is important to identify who is bothered by a symptom. Frequently, a patient with advanced cancer cachexia syndrome will be comfortable not eating and relieved when unburdened of the expectation of eating, while caregivers or family will project on the patient

Table 3. Screening Questions During the Physical Assessment

How long have you had (symptom)?
Are you having this (symptom) all the time or on and off?
How would you describe what you are feeling?
Is the (symptom) staying the same, getting better, or getting worse?
Using a scale (provide a scale), what is the lowest you have been in the past day? The highest? Where are you now? Where would you be satisfied?
Do you notice any change depending on what you are doing?
Does anything make the (symptom) better? Worse?
Is it (symptom) keeping you from sleeping (etc)?
To what extent does the (symptom) interfere with what you want to do?
Is the (symptom) causing problems in your relations to others?
Have any treatments helped your (symptom)? How much?
What do you think is causing it (symptom)?
What does it (symptom) make you think about?
Does it (symptom) frighten you? Why?

their own sense of distress. It is helpful to have patients prioritize the symptoms in the order of their distress. Some quality-of-life measurement tools incorporate this.⁸

Occasionally, the practitioner finds that a simple remedy, such as an opioid, will address several symptoms. For example, treatment of cancer-related pain will improve control of pain, anxiety, depression, sleeplessness, and nausea if cancer pain is the root cause of the other problems. In more difficult cases, several therapies, pharmacologic and nonpharmacologic, may be needed to address any one of these symptoms.

Assessment of pain has been the paradigm for assessment of other symptoms. Pain assessment tools have been developed and validated.⁹⁻¹¹ A 10-point scale is commonly used for the patient's report of pain. The scale ranges from 0 to 10, where 0 = "no pain," and 10 = "pain as bad as one can imagine." Some populations find it easier to respond to graded symbols or faces to rate their symptom. Symptom assessment scales have been used and validated for nonpain symptoms such as dyspnea,¹² impaired cognition,¹³ and fatigue.¹⁴ Some stress the importance of selecting instruments for symptom measurement that have been validated in a specific disease population:¹⁵ ie, dyspnea in chronic obstructive pulmonary disease is a different experience than the dyspnea associated with cancer.

In some cases inquiry about the meaning of a symptom to an individual will open the door to a more profound understanding of that person and his or her needs.

There is a world of difference in the needs of a patient whose difficulty breathing makes him or her think, "I need a new oxygen tank" and one who says, "This is what I get for smoking!" The physical dimension of palliative care assessment is completed by the determination of functional capabilities and inquiry into the impact of physical limitations on the patient's daily routine, safety, sense of self, and relationships (including sexual intimacy) to others. The physical examination completes the physical assessment either at the time of the interview or at a time agreeable to the patient.

See Table 3 for screening questions used in the physical assessment.

Psychologic assessment

The assessment of the psychologic dimension of the patient will be well underway during the initial illness narrative and physical symptom review. The state of cognition, including the presence of confusion or delirium, can be observed during that portion of the interview and should be inquired about as well: "Are you confused at times?" or "Has anyone you know noted any confusion?" or "Have you been 'out of it' at times?"

Is there a history of mood disturbance or other psychologic disorder? The patient's affect should be observed and questioned. Is the patient depressed? Anxious? To what extent have any disturbances of mood preceded the current illness? In the opening vignette, the patient described had no previous history of depressive disorder, but he gave an account of unexplained lack of libido (it was attributed to job stress) for one year before diagnosis of his cancer. In advanced illness the cognitive signs of depression (hopelessness, helplessness, guilt, sense of worthlessness, and suicidal ideation) are more helpful in determining depression than the vegetative symptoms of fatigue, anorexia, poor concentration, and sleep disturbance.¹⁶

When learning about the patient's psychologic adaptation to illness (coping mechanisms) it is helpful to ask the patient how he or she reacted to earlier major life events in which there may be parallels to the current situation. Some of these reminiscences of experiences where all control had been threatened or surrendered (critical illness, surgery, war, or imprisonment) can be revealing and liberating: "I have been in situations like this before and somehow it all worked out," or they can provide a clue that additional expertise may be needed.

The presence or absence of suicidal ideation should be

determined. Fear of finding suicidal ideation or encountering a request for physician-assisted suicide shouldn't deter the surgeon from this line of inquiry. If a request for physician-assisted suicide is made, the correct response in the context of palliative care is further inquiry about the reasons for the request, not endorsement or rejection. Other important issues in the psychologic assessment are the meaning of the illness, the emotional state, fears related to the illness, and unresolved personal issues.

Terminal illness prompts numerous emotions and adaptations including denial, anger, bargaining, depression, humor, fear, avoidance, intellectualization, irritability, lability, grief, and peacefulness. It has been noted that these reactions are idiosyncratic and simultaneous and consistent with a given individual's pattern of emotional reaction to major difficulties in the past, not a stage in the process or the diagnosis.¹⁷ Generally, patients find resolution and homeostasis through the shifting tides of these emotions, which can occur simultaneously, change rapidly, or be very persistent. The interviewer can assist the patient by giving him or her the opportunity to identify these emotions.

Prevalent fears generated by incurable illness are fear of uncontrolled pain and fears related to the loss of identity and dignity. One recent study of patients with HIV-1 or AIDS¹⁸ identified (1) disintegration that resulted from symptoms and loss of function and (2) loss of community, defined as the progressive diminishment of opportunities to initiate and maintain close personal relationships as the two main factors in the desire for euthanasia and assisted suicide. The fear of being a burden to others, such as the olfactory burden of multiple fistulas or a fungating wound, is closely related to the ultimate fear of abandonment, because such a burden can result in abandonment. For many, this fear may be even greater than the fear of pain. In instances of refractory distress, manifested by restlessness and agitation, unresolved personal issues, spiritual questions, and active dying itself should be considered in the differential diagnosis.

Referral should be considered in these situations where a higher level of expertise in psychosocial or spiritual care is needed. Consideration for psychiatric referral should include patients with persistent pain, unusually intense grief, depression, anxiety that is unassuaged by exploration and reassurance, delirium, substance abuse, and requests for hastened death.¹⁹ In cases where referral for greater expertise in these matters is deemed

Table 4. Screening Questions During the Psychologic Assessment

Does everything happening make any sense to you?
What do you think will happen next?
How has your illness affected your life?
How would you describe your mood?
What do you see as the biggest problem facing you now?
What frightens you most about your illness?
How well do you think you are coping now?
Do you feel depressed?
Have you ever thought of taking your life? Do you have a plan?
Have you been sad? Frightened? Anxious?
Are you afraid of being a burden to others?
How have you handled tough times in your life previously?
Who do you turn to for support in tough times?
Have you ever had problems with depression, alcohol, or other psychological difficulties before your illness? Did you ever have treatment for these?
Are you afraid we won't be there when you need us?

appropriate, you need to know who it is you are referring to. Some professionals in the behavioral sciences may be no more psychologically or cognitively prepared for the management of patients with advanced, incurable disease than any other medical specialty.

See Table 4 for screening questions for psychologic assessment.

Assessment of decision-making capacity and communication

Decision-making capacity may already be apparent during the early part of the assessment, although, if questionable, should be assessed carefully to determine the degree of compromise, if any, and to determine who is authorized to speak on behalf of the patient if the patient is incapacitated. Specific decision-making capacity, such as a decision to forgo intubation or operation, can be retained in the face of other significant cognitive deficits. In some cases, referral to a psychologist or psychiatrist will be necessary to more accurately determine decision-making capacity.

In order for a patient to give meaningful consent, the patient must understand the circumstances of the illness, that he or she is authorizing the decision, the consequences of having a given therapy, the consequences of not having the therapy, and that the decision is consistent and free of coercion. It is the job of the assessor to ensure that the patient is free of coercion. Coercion can come in various forms—voiced expectations: "You wouldn't want to do this to your family"; passive-

aggressive gestures: “Well, do what you want to do; I have other patients to see;” “medical hexing”: “If you don’t undergo amputation you will die in agony”; and physical duress from poorly controlled symptoms.

This phase of the palliative care assessment is a good time to identify any existing advance directives (“living will”) such as the use of antibiotics or other specifically relevant therapies, clarifying existing “Do not resuscitate” orders, or initiating the process of creating an advance directive document. This is also a good time to determine, from the patient, just who is permitted, and to what extent, to be in the information loop regarding the patient’s care. Language barriers should also be assessed at this time to determine the need for a professional interpreter on an ongoing basis.

Social assessment

An equilibrium exists between an individual and his or her social setting: the individual’s circumstances can have an impact on the setting and the setting can influence the individual’s circumstances. This is readily apparent in advanced illness when the patient is highly dependent on others for his or her needs. If not handled properly, potentially devastating financial consequences to survivors²⁰ can ensue.

Screening questions should assess distress and strength in the social dimension, identify caregivers for the patient, financial resources or liabilities, domestic needs, and community resources such as hospice, support groups, or veteran benefits. For the patient, vulnerability or strength in any of these areas is often the main determinant when considering further medical treatment. Medical social workers are considered core members of a hospice or palliative care interdisciplinary team because of their familiarity with social benefits and family counseling. Surgeons lucky enough to have access to these professionals would be well rewarded to include them in planning discussions with their patients. Often, by physician order, the social worker is asked to discuss hospice care with patients. This should not be done without previous discussion between the patient or the surrogate and the referring physician or surgeon because of (1) the specific prognostic criteria of the Medicare Hospice Benefit²¹ (patient must be terminally ill with a prognosis of 6 months or less, if the illness runs its normal course), and (2) the philosophical shift in goals of care a hospice referral implies.

Spiritual assessment

Because of the transcendent nature of spiritual issues far removed from the concerns of the operating room, many surgeons might balk at the prospect of inquiry into spiritual matters. One preeminent surgeon with deep insight into spiritual matters and surgeons recently wrote, “Surgeons are technicians for whom the spirituality of death and the dying process is terrifying.”²² For some surgeons, it may be just as difficult to resist projection of their own spiritual or religious views as their opinions regarding desirable physical or social status. Not resisting this impulse risks inadvertent curtailment of the patient’s own spiritual growth.²³ Despite the uneasiness some may feel about inquiry into spiritual matters, there is evidence that patients generally welcome this.²⁴

Most would distinguish spirituality from religion. Spirituality is an innate capacity for transcendent yearning; religion can be defined as a body of theologic belief shared in a community of faith based on the capacity of spirituality. Spiritual suffering, which may be manifested in lost hope, meaning, and sense of integrity, is almost always present in life-threatening illness. Because physical and spiritual domains are so highly connected, control of physical symptoms can rarely be optimized without alleviation of spiritual pain. Spiritual dysphoria²⁵ can be part of, or expressed as, physical symptomatology. Because of the relational nature of the spiritual dimension, this dimension is present whenever a surgeon interacts with gravely ill patients and their families.²⁶ The shared sense of mystery that results from arousal of these spiritual instincts is probably one of the most reliable tests that “the lens” that focuses on humanity instead of disease is coming into focus, however darkly.

Not surprisingly, there is no universal definition for spirituality or intervention for spiritual distress, though there are many helpful clues and questions that can identify spiritual distress and strength. Language that is laden with existential meaning: “I have lived a blessed life. . .” or “I(We) have been tortured by all this,” signals a spiritual undercurrent. “Why me?” type of questions are often entry points for deeper self-awareness in critical situations. Sometimes more direct expressions of spiritual anguish will be heard: “God has let me down,” or “I am mad at God right now!” Interventions for other forms of distress (physical, economic) where symptoms would normally be reduced are other indications of possible spiritual turmoil. Some individuals may not recognize or acknowledge spiritual distress, and as a general

rule patients will not address spiritual issues until other forms of distress are under some degree of control.²⁷

Inquiry should be made about the presence of religion or other expressions of spirituality in the patient's life, his or her own degree of participation, and its importance. Individual expressions of faith or spirituality should not be overlooked or dismissed. Assistance (contacting a patient's pastor or rabbi) should be offered to maintain the patient and family's religious or spiritual life, and ensure that no important rituals or rites are overlooked. The surgeon is not expected to pray with patients, but is obliged to make prayer possible for the patient and family. The surgeon will want to determine who should assist with spiritual care. Hospital chaplains have the advantage of familiarity with serious illness; the individual normally entrusted with spiritual guidance has the advantage of an established relationship.

The timing and tone of inquiry about spiritual intervention comes with experience. For example, "Your medical (surgical) needs are important to us, but we are also concerned about your emotional and spiritual well being. Can we talk about this?"²⁸ A spiritual screening tool going by the acronym FICA, has been developed for physicians.²⁹ The questions address the presence of faith and belief (F), the importance of faith to the individual (I), identification of the patient's community of faith (C), and how the patient would like the physician to address spiritual issues (A).

See Table 5 for sample screening questions related to the spiritual assessment.

Practical assessment and anticipatory planning for death

As staging for palliative care nears completion, practical issues and anticipatory planning for death and its aftermath tend to come into sharper focus: designation of caregiver, travel arrangements for treatments, equipment delivery, future care of pets, etc. Provision of prescriptions and verification that the instructions for their use have been comprehended is critical to sustain whatever gains about symptom control have been made in the hospital. Physician followup visits should balance the need for direct supervision and patient contact with the patient's freedom to pursue life's closure with as few distractions as possible. Frequently, I have seen physician office appointments made for 2 weeks after hospital discharge scheduled to the chagrin of family already all too aware that if the patient were actually still alive, such a

Table 5. Screening Questions During the Spiritual Assessment

Do you consider yourself a religious or spiritual person?
What sustains your hope?
Do you have religious or spiritual beliefs that help you through difficulty?
What gives your life meaning?
How important is your faith or belief in your life?
Does your faith influence your feelings about your illness? Your surgery?
Do you see any possible conflicts between your healthcare and your beliefs?
Do you belong to a community of faith?
Is there a group of people particularly important to you?
How is your faith working for you today?

visit would be excessively burdensome. Most patients would rather spend that time doing something other than being told that nothing more can be done. More poignantly, unrealistic scheduling can raise the spectre of false hope and reinforce denial.

The time of discharge from a hospital when an individual is not expected to recover is one of the most anxiety-producing experiences a patient and family can experience. The line between hope and helplessness is very fine, as it is in all vulnerable situations, and it is easily crossed by poor preparation in the details. A call to the home from the surgeon to inquire about "safe" arrival at home in these circumstances is equivalent to the postoperative check we would do automatically for our inpatients.

I often ask patients what they would like to do with the time remaining and if there are things they need to complete. Realistic estimates of time are particularly important for this process of closure, especially when it involves travel of loved ones from a distance. Prospective planning such as this is one of the coping mechanisms for impending loss to the patient and family.

Preparation also includes sharing information and explanation about the anticipated manner of death, including the signs ("death rattle") and symptoms of approaching demise. Hospice programs have pamphlets that are quite helpful in acquainting families with these changes while providing them reassurance that much of what they will see is normal. The surgeon should address the specific changes expected as a result of progressing disease. Will it be a slow peaceful death of progressive cachexia or coma or will demise occur swiftly and with little warning such as in a carotid artery blow-out? Who

should be called at time of death? Should the patient's family call emergency rescue or the hospice nurse on call?

The surgeon should not be afraid to inquire about funeral and burial arrangements. The surgeon may be asked and should be ready to respond or refer questions about the role of autopsy, possible coroner's examination, and anatomic donations. Inquiry about anatomic gifting should be made not only to satisfy the minimum professional and legal standard, but also as an acknowledgment of the importance of this to the individual. In cases where the relationship is more secure, the surgeon may wish to broach the subjects of postdeath rituals or ceremonies and an individual's legacy as further demonstrations of genuine interest.

In conclusion, the staging procedure for palliative care not only provides a reliable patient-centered platform for further interventions, but it also creates a unique bond, not unlike that which forms between a surgeon and an individual he or she has operated on. Because of the inherent vulnerability of a patient revealing his or her innermost fears and yearnings while in a physically precarious condition, this intervention is as "invasive" as any anatomic operation performed and deserves the same attention and skill. This cognitive operation, as all others, is based on many small, careful steps and a few big steps, some of which are irreversible. Given a familiar format and practice, surgeons have every chance of doing this as well as their nonsurgical colleagues.

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Appendix

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