"I Had No Choice": Older Patients' Perspectives on Shared Decision-Making During Acute Surgical Emergencies

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INTRODUCTION: Shared decision-making is the preferred approach to value-laden treatment decisions; however, challenges exist for older adults with acute life-threatening surgical conditions in which the risk of adverse outcomes are very high and success is uncertain. We sought to better understand older patients' lived experience making decisions to undergo emergency general surgery procedures.

METHODS: Adults 65 years and older who underwent 1 of 7 common emergency general surgery procedures with a length of stay longer than 5 days at 3 Boston-area hospitals were included. Semi-structured phone interviews were conducted at 3 months post discharge. Transcripts were reviewed and coded independently by surgeons and palliative care physicians to identify themes.

RESULTS: Thirty-one patients were interviewed. Patients viewed the decision whether to undergo the procedure as a choice of life over death and valued prolonging life. They thought that there was "no choice" but to proceed with the operation. They thought that their in-the-moment decision-making was severely limited by time constraints, intolerable symptoms, and confused thinking (Table).

CONCLUSIONS: Older patients who underwent emergency general surgery procedures thought that undergoing the procedure was the only reasonable treatment choice; however, patient participation in decision-making was limited by time constraints, as well as patients' symptoms and confusion. These barriers must be considered during deliberations about an operation and informed consent.

Table. Patient Reflections on Decision-Making

Variable	Reflection
Thinking about when you got sick with your [DIAGNOSIS], can you tell me what you were thinking when you decided to have the procedure?	
Patient perception of decision for procedure	
No other options/one correct option	". . . no way I could not have the surgery. . . **I didn't really get a yes or no** on because if I didn't have the surgery **I would have died**."
Patients value prolonging life	". . . everybody loves life, so if it's a chance that that wasn't the end all and be all of my life **then I would like to live.**"
Patient participation in decision making is hindered by:	
Time constraints/ emergency	"I don't think anything, as I said it happened, by the time they operated it was I think **midnight or close to it and we had to move fast I guess**, so I don't think there was anything different they could have done."
Symptom burden	"I had no choice, I was in **constant pain** with my stomach not able to move my bowels. . . **and nothing helped me**. . . And so they put an NG tube in, probably **the worst thing I've ever experienced in my life**."
Confusion	"I don't even remember anybody telling me that. . . **I was so sick that I didn't even know I was having surgery until I woke up in the recovery room.**"

(*Continued on next column*)

Table. Continued

NG, nasogastric.

Aging Veterans Surgical Wellness Program Improves the Care and Outcomes for Geriatric Patients

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INTRODUCTION: More than 50% of all operations in the US are performed on patients 65 years and older. Geriatric patients require unique assessments preoperatively to ensure optimization and reduce the morbidity and mortality inherently associated with this patient population. A multidisciplinary approach is required to prepare this vulnerable population to undergo operation.

METHODS: The Aging Veterans Surgical Wellness (AVSW) program is a beta testing site for the American College of Surgeons Geriatric Surgery Verification Program at a single academic medical center. A multidisciplinary team composed of providers in all phases of perioperative care performs a preoperative assessment. An inpatient rounding team assess patients daily. In-hospital and postoperative outcomes are chart reviewed on a weekly basis.

RESULTS: A total of 186 patients were enrolled in the AVSW program between January 2018 and October 2019. The median age was 79 years (range 75 to 102 years). After implementation

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of the daily inpatient rounding team, 137 patients (73.7%) required interventions that were initially missed by the admitting service, including 115 (61.8%) aspiration precaution order sets and 119 (64%) delirium prevention and screening order sets. Only 7.5% (n = 14) of patients, compared with 10.8% nationally, required readmissions.

CONCLUSIONS: The AVSW program improves the care and outcomes of the geriatric surgery population. Through a multidisciplinary approach, AVSW assesses the patient in the preoperative, postoperative, and post-hospital phases of care, which allows for improved continuity and earlier intervention to improve surgical outcomes.

Do Long-Term Perceptions of Worsened Physical Function Align with Measured Functional Decline in Older Adult Surgical Patients?

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INTRODUCTION: Long-term functional outcomes in older adults are important after surgical procedures and can be evaluated by objective performance measures and patient perception. However, agreement between objective measurement and reported perception is poorly understood.

METHODS: Data from the American College of Surgeons NSQIP Geriatric Surgery Pilot Project (2015-2017) were used to compare 30-day postoperative function by measured performance of activities of daily living and patient perceptions of physical function. Chi-square tests and hierarchical multivariable logistic regression were used to compare functional assessments and identify risks associated with patients perceiving worsened physical function without measurable functional decline at 30 days postoperatively.

RESULTS: Data from 3,930 patients aged 80 years and older from 18 hospitals were included. At 30 days postoperatively, 35% reported worsened perceptions of physical function and 28% had measurable functional decline. Of the patients without measurable functional decline, 23% still reported worsened perceptions of physical function. In this subset of patients, factors associated with discrepant/worsened perceptions of physical function were American Society of Anesthesiologists class IV/V (odds ratio [OR] 2.35; 95% CI, 1.19 to 4.64) and history of congestive heart failure (OR 3.00; 95% CI, 1.84 to 4.87), undergoing an orthopaedic (OR 2.27; 95% CI, 1.25 to 4.14) or emergent (OR 1.93; 95% CI, 1.19 to 3.13) procedure, falling in the year before the operation (OR 1.51; 95% CI, 1.06 to 2.15), experiencing postoperative delirium (OR 1.73; 95% CI, 1.08 to 2.76), and non-home living 30 days postoperatively (OR 4.45; 95% CI, 3.13 to 6.32).

CONCLUSIONS: Even if patients had no measurable, long-term functional decline, nearly 1 in 4 reported perceptions of worsened physical function 30 days postoperatively. Deliberate preoperative discussion of contributing risks, as well as intervention on mutable factors (ie preventing avoidable delirium), can help to align patient perceptions.

Impact of Frailty on Failure to Rescue in Older Patients Undergoing Both Emergent and Elective Ventral Hernia Repair: An NSQIP Study

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