The 30 DAY Mortality Rule in Surgery: A Number that Prolongs Unnecessary Suffering in Vulnerable Elderly Patients (SA538-C)

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Objectives

- Examine the origins of the 30-day post-operative mortality rule for surgery.
- Identify positive and negative outcomes related to public reporting and private reporting of surgical 30 day post-operative mortality.
- Identify alternate quality measurement options for surgical performance, and models to integrate palliative medicine into surgical care.

Background: Public reporting of surgical performance is considered necessary in order to demonstrate quality assurance across medical centers. Thirty day postoperative mortality remains an accepted quality measure. However, this measure may result in unintended consequences, including delays in discussing goals of care and prolongation of life in terminally ill postoperative patients who may instead wish for comfort oriented care.

Case Description: Ms. S, a 94 year old pre-frail female with critical severe aortic stenosis, consented to a trans-aortic valve repair. Her primary goal was to continue living in her condominium independently after intervention. The procedure was complicated by a tear in the left ventricular apex, which necessitated re-exploration and intraoperative cardiopulmonary resuscitation. Her postoperative course was complicated by refractory atrial fibrillation, pulmonary edema, acute kidney injury, a right embolic stroke, and a loculated lung requiring video-assisted thoracic surgery. Ms. S expressed despair, stating, "I will never see my condo again," and stopped eating. Geriatrics was consulted and recommended that a goals-of-care discussion take place, however the team continued to be optimistic, and wished to defer discussion. Four weeks postoperatively Ms. S developed septic shock, requiring intubation and vasopressor support. Postoperative day 30, the surgical team consulted palliative care, and after a goals of care discussion with the family, Ms. S was terminally extubated on postoperative day 31.

Conclusion: With the increase in the aging and frail population, early palliative care consultation to clarify the benefit-burden ratio of a surgical intervention is crucial. Interventions to improve patient autonomy include preoperative palliative care consults in the frail elderly and including geriatric and palliative care curricula into surgical training. We will discuss improving risk-adjustment algorithms, nonreporting of exceptional risk patients, and use of more comprehensive patient-centered measures that focus on quality, dignity, and morbidity rather than only mortality.