

Concerns of Family Caregivers of Patients With Cancer Facing Palliative Surgery for Advanced Malignancies

Tami Borneman, RN, MSN, David Z.J. Chu, MD, Lawrence Wagman, MD, Betty Ferrell, PhD, FAAN, Gloria Juarez, RN, PhD, Laurence E. McCahill, MD, and Gwen Uman, RN, PhD

Purpose/Objectives: To describe the concerns of family caregivers of patients undergoing palliative surgeries for advanced malignancies.

Design: Descriptive study with repeated measures.

Setting: A National Cancer Institute-designated Comprehensive Cancer Center in the western United States.

Sample: Family caregivers (N = 45) of patients with cancer.

Methods: Family caregivers were assessed prior to planned palliative surgery and at two weeks and six weeks postsurgery. Quantitative assessment of caregiver quality of life (QOL) occurred at each interval. A subset of nine caregivers also participated in a structured interview presurgery and at two weeks postsurgery.

Main Research Variables: Caregiver concerns, QOL, decision making.

Findings: Family caregivers have important QOL concerns and needs for support before and after surgery for advanced disease. Psychological issues were most pronounced, and common concerns included uncertainty, fears regarding the future, and loss. Family caregivers have concerns about surgical risks and care after surgery and voiced recognition of the declining status of patients.

Conclusions: Surgery is an important component of palliative care and profoundly impacts family caregivers of patients with cancer. The needs of family caregivers are multiple and complex, requiring ongoing assessment to provide interventions that help them cope and ultimately improve their QOL. This important topic requires further research and clinical attention.

Implications for Nursing: Findings suggest that family caregivers experience their own trajectory during the course of their loved ones' cancer, with surgery being a part of the course. This includes their profound emotions that may swing like a pendulum from one minute to the next. Nurses need to assess family caregivers in addition to patients to provide support and resources that will help increase caregivers' QOL.

Key Points . . .

- ▶ Surgery is an important component of palliative care and has a profound effect on family caregivers of patients with cancer.
- ▶ Psychological issues are particularly pronounced, and common concerns include uncertainty, fears about the future, and loss.
- ▶ Family caregivers are anxious about surgical risks and care after surgery.
- ▶ The needs of family caregivers are multiple and complex, requiring ongoing assessment to provide interventions that help them cope and ultimately improve their quality of life.

is to achieve the best quality of life (QOL) for patients and their families. The WHO definition and the literature consistently acknowledge families as a focus of palliative care.

From the surgical literature, Finlayson and Eisenberg (1996) provided three definitions of palliative surgery: (a) relief of symptoms with prior knowledge of the impossibility of removing the whole tumor, (b) resection with small or large amounts of residual tumor left at the end of the procedure, and (c) resection for recurrent or persistent disease after failure of primary treatment. Easson, Asch, and Swallow (2001) placed the need for palliative surgery in two procedural categories: (a) palliative, where the goal is symptom relief, and (b) supportive, where a technical intervention is performed as part of the multidisciplinary plan of care.

Tami Borneman, RN, MSN, is a research specialist in the Department of Palliative Care in the Lombardi Cancer Center at Georgetown University Medical Center in Washington, DC; David Z.J. Chu, MD, is a surgeon in the Department of General Oncologic Surgery, Lawrence Wagman, MD, is chair of the Department of General Oncologic Surgery, Betty Ferrell, PhD, FAAN, is a research scientist in the Department of Nursing Research and Education, and Gloria Juarez, RN, PhD, is an assistant research scientist in the Department of Nursing Research and Education, all for the City of Hope National Medical Center in Duarte, CA. Laurence E. McCahill, MD, is a surgeon for the Department of Surgical Oncology at the University of Vermont in Burlington; and Gwen Uman, RN, PhD, is a biostatistician for Vital Research, LLC, in Los Angeles, CA. Research support was provided by the American Cancer Society. (Submitted April 2002. Accepted for publication December 30, 2002.)

Digital Object Identifier: 10.1188/03.ONF.997-1005

Among the therapies available for cancer, whether curative or palliative, surgery remains a primary treatment. Approximately 90% of patients with cancer undergo a surgical procedure (Polomano, Norcross, & Wurster, 1994). Surgery has greatly improved in recent years because of advanced technologies that facilitate diagnosing, staging, treating, and palliating cancer (Field & Cassel, 1997; Hanson & Cuning, 2000; Mast, 2001).

The words palliate and palliative are defined as “reducing the severity of . . . affording relief, but not cure” (Anderson, 1994, p. 1217). The World Health Organization (WHO) (2003) defined palliative care as actively caring for patients whose disease is not responsive to curative treatments, including providing pain control, symptom control, and support for psychological, social, or spiritual problems. Overall, the goal