SPECIAL ARTICLE

Patient-Centered Informed Consent in Surgical Practice

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Objectives: To review the medical, ethical, and legal basis of the doctrine of informed consent for surgery and its complications, particularly for an incapacitated patient who requires a surrogate decision maker; to discuss the elasticity of the consent doctrine, whether surgical consent encompasses consent for surgical complications, and emphasize the importance of communication and shared decision making in the context of the patient-surgeon relationship; and to discuss patient and surrogate refusal of treatment, standards of surrogate decision making, barriers to effective communication, the role of the hospital ethics committee in resolving disputes over treatment, and how to reconceptualize surgical consent in the context of patient-centered medicine.

Data Sources: We reviewed PubMed citations for informed consent in surgery, patient-physician communication, shared decision making, patient-centered medicine, and consent guidelines published by specialty societies, particularly the American College of Surgeons and the Society for Critical Care Medicine.

Study Selection: We selected articles in which issues of consent for surgical treatment were discussed or measured.

Data Extraction: We extracted data relevant to questions of consent in surgical practice.

Data Synthesis: We studied qualitative aspects of the consent doctrine.

Conclusions: Surgical consent is not an event or a signature on a form but is an ongoing process of communication that continues throughout preoperative, perioperative, and postoperative care. In the context of patient-centered medicine, consent is best conceptualized as shared decision making with patients or their surrogates.

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INFORMED CONSENT IS AN ESTABLISHED ethical and legal requirement for surgical treatment. It has important roots in Anglo-American political theory and has been articulated in the law in a series of judicial decisions.[1,2] Informed consent also forms the ethical foundation for the modern practices of shared decision making and patient-centered care.[3] Many elements of surgical consent are generally understood, but several issues remain controversial: (1) does a patient's preoperative consent encompass postoperative complications? (2) can surrogates refuse treatment to which patients had previously consented? (3) what is the role of the ethics committee in resolving treatment disputes? and (4) how should deaths resulting from surrogate decisions to limit treatment be counted in operative statistics?

Serving as hospital clinical ethics consultants, we have encountered a few cases in which the previously described questions became the subject of heated arguments with family members over treating surgical complications in patients lacking decisional capacity. The surgeon in each case maintained that by consenting to surgery, the patient also implicitly consented to treatment of the expected complications. One of the surgeons further maintained that without the patient's consent for treating complications, he would not have operated on the patient in the first place. We address the difficult surgical consent issues by first analyzing the principles of informed consent and refusal by patients and their surrogates, and stressing the professional duty of surgeons to communicate effectively. We make recommendations for managing conflicted situations and offer suggestions for improving surgical consent.

THE THEORY OF CONSENT

The legal doctrine of consent was famously articulated by Justice Benjamin Cardozo in *Schloendorff v Society of New York Hospital*, a case in which a surgeon failed to obtain consent for a hysterectomy. Cardozo, maintaining that surgical consent was mandatory because "every human being of adult years and sound mind has a right to determine what shall be done with his own body,"[4(p129)] connected consent with the

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principle of self-determination. The wrong committed in this case was battery by unconsented touching. The emphasis in this ruling was on consent.

In *Canterbury v Spence*,[5] a federal appeals court addressed physicians' duty to disclose information or inform. Surgeons were directed to disclose "material" risks of surgery to the patient. Material facts were defined as the information patients needed to make a medical decision.[5] In *Arato v Avedon*,[6] the California Supreme Court ruled that a patient's estimated life expectancy is another material fact that surgeons need to communicate preoperatively for valid surgical consent in the setting of critical or terminal illness.[7] These and related cases generated changes in surgical culture by defining the standard of care to which surgeons must adhere. Now, inadequate informed consent is usually considered a tort of negligence rather than battery. The courts enhanced patient self-determination by explicitly requiring and clarifying the nature and content of a patient's informed consent for surgery.

Beyond the law, informed consent is the cornerstone of ethical medical and surgical practice because it enshrines respect for patients. It acknowledges that patients are autonomous persons endowed with dignity and the basic human right of self-determination. Informed consent underscores respect for patients' rights to make decisions for themselves according to their own concept of what constitutes the good life, and with freedom to act on their decisions.

Because of its legal origins and the requirement for the patient's signature on a printed consent form, some surgeons view consent solely as a legal prerequisite that often is delegated to a junior colleague. But the patient's signature on the surgical consent form is not the patient's consent. The patient's consent happens during the process of dialogue with the surgeon, during which the patient learns and understands the reasons for the procedure and its risks and benefits, understands alternative courses of action, has questions answered, and agrees that it should be done. The signature on a surgical consent form is merely the culmination and formalization of this preceding consent discussion and agreement. Thus, the signed consent form simply represents evidence of the patient's consent.

A patient's (or surrogate's) informed consent generally is required before diagnostic and treatment interventions, except in cases of emergencies, threats to public health, or danger to self or others. The emergency treatment doctrine authorizes all physicians to provide emergency treatment without explicit consent based on the concept of presumed consent, provided that the emergency treatment administered is the generally accepted treatment for such cases.

Implicit in and intrinsic to the concept of consent for treatment is the option of refusal. In *Cruzan v Director, Missouri Department of Health*,[8] the US Supreme Court ruled that all US citizens have a constitutional right to refuse unwanted therapy, a right residing in the due process clause of the 14th amendment. Authorized surrogates can exercise this right of refusal on behalf of the incapacitated patients they represent. This right of refusal pertains to all therapies, including life-sustaining therapies and artificial hydration and nutrition, without which patients will die.[8,9] Without a right to refuse, informed consent is meaningless and self-determination becomes impossible.

In the presence of a patient's or surrogate's refusal of therapy, surgeons may strongly urge the acceptance of recommended therapy by explaining the reasons the patient will be healthier with the recommended treatment and emphasizing the risks of not doing so. Family members and friends may be enlisted to help persuade the patient or surrogate that treatment refusal is a mistake. But there are few instances in which a well-meaning surgeon is ethically or legally justified to coerce a patient or override a patient's valid refusal of surgery. For paternalism to be ethically justified in this setting, the patient's decision to refuse surgery must be proved to be seriously irrational.

Informed consent is operationalized in surgical practice through the doctrine of shared decision making.[10] In shared decision making, the physician and patient compose a decision-making partnership. The physician contributes information about diagnosis, prognosis, and treatment options, with risks and benefits, and frequently provides a medical opinion and a treatment recommendation. Patients contribute their unique set of values, preferences, and health care goals through which they interpret the treatment recommendation. Together, physicians and patients agree on a course of treatment that is then carried out.[11,12] The shared decision-making model represents the best blending of physician expertise and patient choice.[13]

Informed consent is best viewed as a process, not an event. It is an ongoing dialogue between patient and surgeon throughout the patient's care. It begins with a preoperative examination and continues through surgery and postoperative treatment. At every stage, the surgeon explains the nature of the illness and the recommendations for treatment, with their reasons. Good patient-surgeon communication fosters good consent. Patients' decisions for treatment may change over time as a result of changes in the patient's condition, and patients may change their minds. Through effective communication, the consent process is sufficiently elastic to permit a wide range of decision making in surgical practice. Thus, informed consent is best viewed as a process of patient-centered decision making.

Practicing informed consent can be viewed as an exercise in communication that challenges professional competence. The goal of communication is mutual understanding. The patient tries to grasp what surgical treatment involves, how it matters to the patient's welfare, and how it will affect the patient's life in the short and long term. The surgeon tries to understand the patient's health goals, preferences, expectations, and fears. Communication requires dialogue, including inviting the patient to ask questions to better comprehend what surgical treatment means and plausible alternatives. In some instances, it takes time to develop understanding, whereas in others, it may happen quickly. Information overload may impair patient understanding. Knowing what and how to communicate is a skill that surgeons should develop and incorporate in teaching programs for trainees. Deficient skill in communication is a common cause of professional liability.

THE PRACTICE OF CONSENT

Three conditions must be met for valid consent.[14-17] First, the patient must have the capacity to make a health care

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decision. Incapacitated patients do not lose their right of consent; it is transferred to an authorized surrogate decision maker to exercise on their behalf. Patients with the capacity to provide consent have the following abilities: (1) they understand they are ill and require treatment, (2) they understand their treatment options and the general risks and benefits of each, (3) they have the capacity to make sense of the information presented and can process it rationally to reach a decision that furthers their health care goals, and (4) they have the capacity to communicate their wishes.

The second element of valid consent is that patients receive adequate information. The precise amount of information that satisfies this requirement remains controversial. Most jurisdictions apply a reasonable person standard: adequate information is that which a reasonable person requires to make a medical decision. To make a rational health care decision, reasonable people need to know their choices and the general benefits and harms of each choice. Physicians should communicate risks of treatment to the extent that they are common or serious. This practice satisfies the material risk disclosure standard articulated in *Canterbury v Spence*.[5] Others have advocated community- or specialty-based standards of disclosure or the innovative disclosure standard that patients should be given sufficient information to prevent them from being surprised by a subsequent outcome.[18]

The third element of valid consent is that the patient consents freely. Patients should not be coerced into accepting treatment by a physician or agency. Making a strong treatment recommendation is persuasion, not coercion. Coercion is the use of threats that a reasonable person would not be expected to resist.[17] It is also subtly coercive to deceive patients through misinformation or by exaggerating the harm of not following the recommended treatment or the benefits of accepting the recommended treatment.

The physician's consent discussion usually should include a treatment recommendation. Some clinical ethicists, devoted to the primacy of respecting patient autonomy, claim that physicians simply should provide a menu of options from which a patient may independently choose. We disagree. In our opinion, patients consult physicians for a treatment recommendation and it is appropriate for a physician to make one. Sick patients feel helpless and dependent. There is evidence that hospitalized patients show evidence of childlike judgment impairment that requires careful physician guidance.[19] Sick patients require physicians' assistance and support in reaching the right treatment decisions for them. It is important for physicians to give the reasons for their treatment recommendation to permit a patient the possibility of agreeing with the physician about the facts but disagreeing with the opinion.

The requirement for documenting the consent process varies among hospitals. Most hospitals maintain lists of those procedures requiring a signed consent form. Some operative consent forms contain lengthy descriptions of conceivable risks and outcomes. The use of such forms is based on an older notion of attempting to avoid a charge of battery; they resemble disclaimer statements more than consents. In the modern era, however, consent is more connected with disclosure and risk taking. It is appropriate to document a refusal of surgery when that choice carries considerable risk. In addition to signing a form, surgeons should enter a note in the patient's record documenting that the full range of surgical complications, including death, had been discussed and that all questions had been answered. The inadequacies of relying solely on a consent form were shown in a study[20] that found that most surgical and procedure consent forms in use in US hospitals are not easily understood by patients and fail to list specific risks and benefits of surgery.

Consent for anesthesia and surgery also should include a discussion of the patient's wishes in several foreseen or anticipated situations. The first situation is handling an unexpected finding during surgery. What does the patient want the surgeon to do if, during the operation, something unexpected is discovered that requires additional definitive treatment? The patient should be asked if she or he is willing to authorize the surgeon to perform an additional procedure. The patient's decision usually depends on the patient's health care goals and the extent to which the additional procedure furthers those goals.

A second situation to be anticipated and discussed is whether the patient authorizes the surgeon to treat foreseen complications of the surgical procedure, such as prolonged mechanical ventilation in the intensive care unit (ICU). For example, it has been shown that preoperative pulmonary function testing in patients undergoing abdominal aortic surgery is predictive of postoperative pulmonary complications leading to prolonged ICU stays on ventilators.[21] Is the patient with chronic obstructive lung disease who consents to an elective abdominal aortic aneurysm resection also willing to consent in advance to treatment of the expected postoperative respiratory complications? If so, for how long is the patient willing to receive ICU mechanical ventilatory care postoperatively?

A third issue is determining whom the patient wants to act as a surrogate if the operation or its complications render the patient incapacitated. Ideally, the identified surrogate decision maker should know the patient's values and preferences for treatment, judge how each additional intervention may or may not further them, and be willing to uphold them on the patient's behalf.

There is little empirical literature on physicians' consent behaviors in practice. Several studies[22-24] have shown that physicians' consent behaviors generally have been poorly integrated into their practices. Furthermore, there remain widespread myths and misunderstandings by physicians of the ethical and legal requirements of informed consent.[25] The amount of information patients comprehend also has been questioned in a study of patients who consented to carotid endarterectomy. Most patients had false and unrealistic expectations of the benefits and risks of the surgery.[26] Some surgeons have attempted to enhance consent in elective surgery by creating and distributing thorough, detailed, patient-oriented surgical information leaflets containing essential information.[27]

SURROGATE CONSENT

Most of the difficult postoperative treatment questions arise when the patient has lost the capacity to consent. In ob-

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taining consent for an incapacitated patient, surgeons should conduct the same consent discussions with an authorized surrogate decision maker who represents the patient, just as they would have done with the competent patient.

Surrogate decision makers can be appointed formally or informally. All states permit citizens to name a legally authorized surrogate for medical decisions, whose authority becomes activated when the patient loses decisional capacity. These appointments are known variously among states as health care agent, health care proxy, or durable power of attorney for health care. Most statutes vest such legally appointed surrogates with the same legal authority for medical decision making as that enjoyed by the patient. Patients should discuss their preferences for treatment in detail with their agent to permit the agent to adequately represent the patient when it becomes necessary. These appointments should not be executed casually because the surrogate has great power over the patient's health care.[28] Patients should choose an agent whom they trust and who understands their health goals and treatment preferences.

Several states have enacted an additional health care proxy statute that automatically names a legally authorized surrogate in the absence of a previous health care agent appointment in certain medical circumstances of incapacity. The surrogate is designated from a statutory priority list of close relatives. This automatic designation is helpful to surgeons in clinical practice because it immediately creates and identifies a legally authorized surrogate.[29]

In states without such a statute, surrogate appointments become complicated if the patient failed to name an agent before losing capacity. In practice, physicians often consider family members as a surrogate, a practice based on common law assumptions, even though a family member's legal authority is questionable in some jurisdictions. The moral basis for this practice rests on the assumption that close family members are more likely than anyone else to know the patient's preferences and to care more than anyone else about the patient's welfare. The degree of closeness of the relationship generally determines who in a family can best act as surrogate. Spouses or partners living together in a committed relationship usually receive priority because they are most likely to be closest.

When no single person is closest, family members often act as joint surrogates. This arrangement works in most circumstances as long as 2 conditions are met. First, the family members must agree on a course of action based on what they mutually agree the patient would have wanted. The absence of this condition often appropriately triggers an ethics consultation.[30] Second, the family decision must be consistent with standards of good medical care and, thus, agreeable to the treating physicians.

Surrogate decision making is often a lonely, guilt-ridden, and anxiety-provoking role. Surgeons can assist surrogates in fulfilling their difficult task by explaining the expected standards they should use to reach decisions. These standards have an ethical and a legal basis, and have been cited in numerous judicial decisions involving surrogate medical decision making. First, the surrogate should follow the patient's expressed wishes. If the patient previously made clear a wish for a specific treatment in a specific circumstance, as expressed in a written or an oral directive, this wish should be followed because doing so furthers the patient's self-determination. But because most people cannot accurately anticipate their eventual medical circumstances, the standard of expressed wishes usually cannot be used.

Second, surrogates should follow the standard of substituted judgment. Here, the surrogate attempts to reproduce the precise decision that the patient would have made based on the surrogate's understanding of the patient's values and treatment preferences. Physicians can help reduce surrogates' guilt by explaining that the decision reached by a substituted judgment is not really their own; the surrogate merely serves as the patient's "mouthpiece" to report what the patient would want to be done in this circumstance. A substituted judgment, thus, can be construed as a positive act wherein the surrogate is able to secure the treatment the surrogate knows the patient would choose were the patient able to consent or refuse. Empirical studies[31-33] on the accuracy of substituted judgment show that errors are frequent, but patients usually willfully accept their surrogate's choice. A surrogate's accuracy in reaching a substituted judgment can be improved by encouraging patients to carefully explain their treatment preferences to their surrogates in advance.

If the surrogate lacks information about the patient's values and treatment preferences, the surrogate should use the standard of best interest. The best interest standard asks the surrogate to render a novel judgment of what course of action is in the patient's best interest by balancing the benefits of the treatment intervention against its burdens. The best interest standard is ethically the least powerful of the 3 standards because the judgment falls fully on the surrogate to render a quality-of-life determination using the surrogate's own value system, which may differ from that of the patient. Best interest judgments must be used in medical decisions for young children and patients with severe retardation and in many guardianship circumstances because the surrogate cannot know the patient's wishes.[34]

Whenever a surrogate reaches a decision to consent or refuse treatment on behalf of a patient, the surgeon should scrutinize the reasons for the decision. Although most surrogates try to faithfully represent patients' interests, at times surrogates may decide for personal gain or emotional reasons unrelated to patients' interests. In these instances, surrogates may reach decisions that are neither what the patient would have wanted nor seem to be in the patient's best interest. Suspecting such a conflict of interest is a valid reason for surgeons to request an ethics consultation. The ethics consultation provides an outside view on the surrogate's motives and conflicts and may help to align the surrogate's view with the patient's best interest.

SURROGATE REFUSAL

A common and vexing clinical situation occurs when a surrogate refuses further life-sustaining treatment on behalf of a patient. The surgeon facing such a refusal should first determine if it constitutes a valid refusal by addressing several questions. Are all elements of informed consent and refusal satisfied? Is the surrogate authorized to make this decision? What are the standards and reasons

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for the refusal of therapy? Is the refusal consistent with the patient's diagnosis and prognosis? Is the refusal consistent with good medical practice? If the surgeon is satisfied that the surrogate is authorized and acting correctly, the refusal should be honored.

Difficulties may arise in those situations in which surrogates refuse a treatment to which a patient had previously consented.[35-37] This apparent conflict immediately raises a crucial question: is the surrogate making a wrong determination or merely exercising the patient's right of self-determination to change his or her mind? In our experience in performing ethics consultations in such cases, we carefully inspect the reasons for such decisions. The intent of a surrogate appointment is to vest another person with the authority and discretion to reach a decision in a novel circumstance that may not have been anticipated by the patient. Presumably, the patient trusts and respects the person she or he has named as a surrogate and wants to vest the surrogate with decisional authority. Statements that patients made earlier may have been predicated on certain assumptions about their underlying health that later in the illness became untrue. The surrogate is empowered with the flexibility to adapt decision making to changes in the patient's health status. Thus, a surrogate's actions should not be categorically restricted to following a patient's previous consent if the overall health context for the consent has changed to render it no longer appropriate or in the patient's interest.

For example, a patient earlier may have consented to receive postoperative ICU and ventilator care when it seemed the patient would recover to her or his previous state. However, postoperatively, the patient experienced multiple strokes, rendering the patient unconscious and paralyzed. Neurologists stated that if the patient survived the hospitalization, the patient would require skilled nursing care and would never again be able to communicate. Given this new circumstance and prognosis, the surrogate may decide based on knowledge of the patient's values that the patient would no longer want to receive life-sustaining therapy. Because the patient's earlier consent had been predicated on a different prognosis that no longer pertained, the original consent no longer remains valid. Patients want their surrogates to have the flexibility to reach novel judgments that are best for the patient in response to unforeseen changes in the patient's condition.

Surrogates should insist that patients for whom life-sustaining therapy is withheld or withdrawn receive proper palliative care. Surgeons should be knowledgeable about and follow comprehensive ICU treatment guidelines for the care of patients in whom life-sustaining therapy has been withheld or withdrawn, such as those published by the Ethics Committee of the Society of Critical Care Medicine[38] and the Principles Guiding Care at the End of Life developed by the American College of Surgeons.[39]

CONTROVERSIES

Several controversial questions remain. First, does consent to surgery encompass consent to treat postoperative complications? The surgeon whose cases led to the ethics consultations and analysis herein believed that the patient's preoperative consent was more conceptual and global, directed to the goal of cure, and, thus, not restricted to the specific means the surgeon could use to exact the cure. By this understanding, the patient's global consent authorized the surgeon to use whatever means were necessary for cure, including the treatment of surgical complications. It is unclear if the patient's understanding was similar to the surgeon's, but that of the patient's family clearly was not.

We understand this perspective but believe that it is desirable for a preoperative consent discussion to explicitly also consider the likely complications of surgery and their management. During the preoperative consent process, we believe it is desirable to anticipate plausible postoperative scenarios with patients without frightening them unnecessarily, to learn their treatment preferences in advance.

A related issue raised in our case is whether surgeons should refuse to operate on patients who will not consent to treatment of expected postoperative complications. Surgeons naturally want to avoid responsibility for performing procedures when limits are placed on their likelihood of success. Also, they appropriately want to avoid feeling responsible for shortening a patient's life. For example, patients undergoing a Whipple resection predictably require intensive care for several days even if all goes well. It would be unreasonable to expect a surgeon to perform this procedure for a patient who refuses consent for the inevitable postoperative ICU care.

But it is coercive for a surgeon to insist that preoperative consent represents a blanket consent that automatically pertains to all postoperative complications irrespective of the subsequent state of the patient's health. The following 3 types of events could change a patient's mind and lead to a desire to lessen the aggressiveness of care: (1) unanticipated changes in the patient's underlying condition (eg, a major stroke, unexpected operative findings of extensive disease, or multiorgan system failure), (2) morbidity or suffering entailed by further aggressive treatment (eg, prolonged ventilatory dependence, an extensive necrotizing wound infection, or renal failure requiring permanent hemodialysis), and (3) a significant reduction in the likelihood of the patient achieving preoperative goals (eg, not being able to return home or to independent living, inability to interact with the family, or inability to resume a meaningful role or pursuit).

While it is impossible and may be harmful to try to discuss all possible serious complications before surgery, it is possible to talk about an individual patient's goals and their importance. It is almost always helpful to include the patient's surrogate in this discussion. This communication can be time-consuming because it necessarily raises opportunities for questions, counseling, and additional meetings. Busy surgeons may not always have the time necessary to conduct detailed discussions. But the full discussion can be shared as a team effort using capable assistants (eg, nurses, psychologists, or social workers) who can explore the patient's preferences in various scenarios in greater depth and involve the surgeon as needed. Many institutions have developed videotapes or brochures for commonly performed elective procedures, explaining in detail relevant facts, including common outcomes for patients.[27] The result of this communication process is the development of

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a mutual understanding that can help prevent and satisfactorily resolve conflicts that may arise during postoperative recovery.

A treatment issue that is less controversial because of established guidelines is the use of "do not resuscitate" (DNR) orders in the operating room.[40-42] The fate of a patient's preexisting DNR order becomes ambiguous when the patient requires an operative procedure requiring general anesthesia. In our experience, most patients who consent to undergo surgery are willing to suspend their DNR order during the perioperative period to permit the surgery and anesthesia to be performed successfully.[43] But they usually want their DNR order reinstated following the perioperative period when resuscitation, if successful, would only serve to prolong mechanical ventilation and other ICU treatment they want to avoid. A surgeon who contemplates performing an operation on a patient with a DNR order should engage in a frank preoperative discussion to clarify the patient's treatment goals and to reach agreement on the limits of the perioperative suspension of the DNR order.

A fourth issue surrounds the effect on the surgeon when a surrogate refuses further life-sustaining therapy. It is important for the surgeon who has done everything possible to help the patient recover to overcome a sense of failure when the patient dies. One solution is for the surgeon to understand the patient's overall health goals and to embrace the concept of a good death by enhancing the patient's palliative care.[44] It is helpful for surgeons to see death in this circumstance as a better outcome than a continued life of suffering, which the patient wanted to avoid. When surgeons appropriately follow a surrogate's refusal of life-sustaining therapy, the patient's death should be regarded as justified and not a clinical failure. This composes a category separate from deaths resulting from technical problems, untoward events such as pulmonary emboli, or overwhelming disease. A death that results from respecting a patient's deeply held values and goals also should not be counted in the same way when recording outcomes of surgical therapy. When presented at a mortality conference, the factors that justified the death should be reviewed, including preoperative knowledge of the patient's preferences, repeated communication with the surrogate, and input from an ethics consultant when requested.

A recent patient illustrated this phenomenon. A 74-year-old man with bleeding and dysphagia from an extensive tumor of the gastroesophageal junction consented to surgical resection for symptom relief knowing his long-term prognosis was poor. Before surgery, he discussed his goals with his spouse–health care agent and surgeon. He wanted to live an active and independent life and did not want prolonged ICU care or a lengthy hospitalization. His tumor was locally extensive, confirming his poor prognosis. Five days postoperatively, he became septic, with respiratory failure requiring intubation. Studies confirmed an anastomotic leak, and when drainage and antibiotics proved insufficient to control the sepsis, a subsequent operation was recommended. The patient was decisionally incapacitated. His wife refused the recommended operation based on his known wishes, the anticipated prolonged recovery period, and the overall poor prognosis. He received palliative care and died 5 days later. At the department mortality conference, his surgeon correctly pointed out that the limits the patient had placed on treating postoperative complications were the proximate cause of his death. Without those limits, the patient might have survived his hospitalization. We believe that surgical outcome quality indicators should incorporate this category of patient-centered decision making.[45]

The final question centers on what role ethics consultants should play in surgical care. From our viewpoint as busy clinicians and chairs of ethics committees in academic medical centers, we believe ethics consultation has a useful role to play in several circumstances. Ethics consultants can advise surgeons in cases in which the patient lacks capacity, there is no legally authorized surrogate decision maker, and there is an intractable disagreement among the nuclear family over consenting to further treatment. Second, ethics consultation may be of assistance when the surgeon suspects the surrogate is making decisions that are inconsistent with those the patient previously indicated or seem not to be in the patient's best interest. Finally, ethics consultants can help conduct dispute resolution as a neutral third party through mediation or other means, when there is an irresolvable dispute regarding a patient's treatment.[46] A third party can assist tense situations by helping family members deal with anger that arises as a normal part of the grief process. As a result, the family may often avoid transferring or focusing their anger on the surgeon and other caregivers, thereby enabling them to appreciate the surgical and intensive care.

IMPROVING SURGICAL CONSENT

Several initiatives can improve informed consent in surgical practice. First, all surgeons should conceptualize consent not as a discrete event but as an ongoing bidirectional process of communication, education, question answering, and listening with the patient or surrogate that proceeds through the continuum of care. The patient or surrogate is best viewed as a partner with the surgeon in a shared decision-making process, converting the process of informed consent to informed decision making. Understanding the values and health goals of the patient is to know the patient as a person and is essential for surgeons to provide appropriate and respectful care. Conceptualizing consent as ongoing communication with patients can help compensate for 2 important pitfalls that have been identified in surgical consent: lack of time for dialogue with patients and poor timing of the consent discussion.[47] Ensuring adequate communication with patients has been shown to have a secondary benefit, a reduction of surgical malpractice claims.[48]

Second, a surrogate decision maker should be identified in advance for any patient who may become incapacitated as a consequence of the surgery or the natural history of the illness. Some physicians show a reluctance to communicate with patients about advance directives and surrogate appointments.[49,50] We strongly advocate that all patients facing elective surgery should be encouraged to execute a legal health care directive document that identifies someone to make decisions for them

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in the event of incapacity. Patients should be further encouraged to have ample discussions with this agent about their health goals and treatment preferences.

Third, during the consent process and thereafter, surgeons should anticipate and discuss foreseen complications with the patient and learn the patient's general treatment preferences for them. Spouses, surrogates, and other interested family members can participate in this discussion to learn the patient's preferences, help the patient formulate treatment options, and later represent the patient's wishes accurately.

Finally, surgeons should maintain an attitude of hope whenever reasonable. Hope is crucial for patients and families to maintain the strength they need to overcome the stresses of coping with postoperative complications. A strong patient-surgeon relationship, nurtured by good communication, mutual understanding, and trust, remains a powerful therapeutic instrument. When a patient or a patient's surrogate prefers a palliative option rather than continued aggressive care, the surgeon should be prepared to support this choice with the same positive attitude.

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