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Where's the Value in Preoperative Covenants Between Surgeons and Patients?

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Abstract

Values, preferences, and goals all affect patient autonomy. Their meanings are often conflated, so this article clarifies them and also distinguishes between *hope* and *wish*. Ethical investigation of preoperative and postoperative clinician-family communication in surgical intensive care units is needed to help mitigate value-incongruent, nonbeneficial operations and postoperative treatments as clinical scenarios unfold.

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Communication as Covenant

Patients value having a sense of purpose, functional independence, meaningful interactions with family, spirituality, and avoiding burdening their loved ones.^{1,2,3,4,5} Surgeons are often more technique-oriented than people-oriented “fixers”^{6,7,8} who feel an intense sense of duty to their patients^{9,10} and strive for technical excellence.¹¹ Preoperative communication in high-risk surgical scenarios has been described as a kind of covenant,¹² with patients (and perhaps their loved ones) often assuming that a surgeon can fix any ailment and respond to complications^{13,14} and with surgeons assuming that patients agree to any postoperative surgical intensive care unit (SICU) interventions.^{5,15,16,17} This article considers how continuing to see **patient-surgeon communication** as a covenant requires deeper ethical investigation into both surgeons' and patients' assumptions and into sources of dissonance between surgeons' and patients' values and goals.

The Nature of the Covenant

In his memoir, *Do No Harm: Stories of Life, Death, and Brain Surgery*, British neurosurgeon Henry Marsh states: “‘informed consent’ sounds so easy in principle—the surgeon explains the ... risks and benefits, and the calm and rational patient decides what he or she wants—just like ... choosing from the vast array of toothbrushes on offer.” He continues: “The reality is very different. Patients are both terrified and ignorant ... [and] will try to overcome their fear by investing the surgeon with superhuman abilities.”¹⁸ Here Marsh contrasts evidence-based reasoning, which he attributes only to

surgeons, and a fear-based approach to decisions, which he attributes to patients. Marsh's characterization of surgeons as reasonable and patients as emotional might be too stark a contrast. Regardless, one ethical upshot is that, in most clinical encounters, information exchange in patient-surgeon communication is value laden on both sides and that the transformational potential of those values must be richly contextualized¹⁹ if informed consent is to be a process that expresses a surgeon's respect for a patient's autonomy²⁰ and through which the covenantal nature of patient-surgeon communication can be upheld.

Keeping the Covenant

The actual process of respecting patient autonomy is messier than clinicians would like,²⁰ devoid of neat risk calculations or tidy formulas for approaching clinician-patient communication,²¹ particularly when medical-surgical care pathway preferences are overshadowed by the enormous influence that existential fear has on human behavior and decision making.²² The high clinical and ethical stakes of postoperative SICU settings can intensify conscious and subconscious fears—of surgeons as well as families—regarding the implementation or **foregoing of life-sustaining interventions** and magnify the critical, life-or-death nature of these decisions.^{2,22} When patients' loved ones look to withdraw life-extending interventions, prioritize patients' comfort, or emphasize making their death as peaceful as possible, a surgeon might be reluctant to acquiesce.^{8,9,13,22} In such cases, it is critical for surgeons to clearly distinguish between their own and their particular patient's values, preferences, and goals.²³ The following working definitions can be helpful:

- *Values* can be understood as stable, fundamental meaning-based concepts (eg, ethical, aesthetic, spiritual) that have broad control over moral agents' (eg, surgeons', patients', patients' loved ones') motivations^{2,23} and actions.
- *Preferences* can be understood as informed by values and as expressing moral agents' inclinations to prioritize one circumstance-specific course of action over another.
- *Goals* can be understood as the objects, aims, or desired *results* that direct moral agents' preferred courses of action.² Importantly, some goals are feasible, others are not.

In informed consent and all perioperative communication for surgical and palliative care, clarifying the suffering that patients are willing to endure for the *possibility* of achieving their goals²⁴ is key to success, since many patients prefer their dying process not to be prolonged, especially if other values (ie, self-sufficiency, dignity, enjoyment, or comfort) are compromised.^{2,3,4,25}

Falling Short

Physician and health care analyst David Eddy first applied a mathematical model to health decision making and concluded that 2 fundamental factors are (1) thoughtful analysis of evidence and (2) value judgments about risks and benefits of medical or surgical courses of action.^{26,27} Acceptable trade-offs (eg, willingness to extend life with specific procedures that will clearly diminish the quality of one's remaining time) and unacceptable burdens^{24,25} are also key features of informed consent and should be clarified, particularly when mortality risk is significant. Patients and their families value clear, compassionate communication that focuses on patients' preferences, goals, and values, as well as patient care that promotes comfort, dignity, and preservation of personhood.^{25,28} Yet, both preoperatively and postoperatively, surgeon-patient-family

discussion is frequently inadequate for imagining end-of-life scenarios, much less for eliciting patients' values about *meaning* in life or *how* they might prefer to die.^{29,30} Physicians regularly fail to consider what matters most to patients. Even though spirituality is a highly prevalent value that becomes more pressing near the end of life,^{31,32} spiritual concerns are rarely addressed by clinicians when patients are in a critical condition.^{30,33} Moreover, when surrogates initiate religious or spiritual discussions in the ICU, the topic is frequently buried by clinicians, who might redirect conversations to medical considerations.³³

Well-meaning surgeons might mistakenly believe that when they lay out treatment options along with intervention-associated risk predictions they are respecting patient autonomy.³⁴ This type of "independent informed choice,"^{35,36,37} however, is seldom beneficent, nonmaleficent, or patient centered.³⁸ As Ezekiel Emanuel and Linda Emanuel explain: "Freedom and control over medical decisions alone do not constitute patient autonomy."³⁵ True autonomy requires critical introspection on one's values prior to exercising one's freedom to act on those values.³⁵ Furthermore, as Daniela Lamas and Lisa Rosenbaum note: "Patients may be asked to choose from a bewildering array of medical options."³⁷ Paradoxically, although freedom and autonomy might be logically thought to promote greater well-being, psychologist Barry Schwartz reminds us that such "choice overload" frequently does not lead to empowerment and emotional health, but rather to greater distress.³⁹ In a recent and novel study undertaken by Leslie Scheunemann et al, family conferences rarely generated value-centered recommendations and fewer than half contained discussion of prolonged physical, cognitive, or emotional impairment among seriously ill patients.²⁹ Soliciting appropriate surrogates' substituted judgment^{40,41} during family meetings can relieve survivors' guilt, anxiety, depression, and posttraumatic stress^{42,43} and mitigate complex grief,^{44,45} but substituted judgment conversations happened in only 13.5% of meetings that Scheunemann and colleagues analyzed.²⁹

Values, preferences, and feasible goals—understood by all parties in the context of either acceptable trade-offs or unacceptable levels of suffering^{24,25}—are needed for substituted judgment and shared decision making^{23,46} and are key to generating preoperative covenants and maintaining ongoing, collaborative postoperative communication in SICU settings as clinical scenarios unfold.^{2,30,47}

Hope and Wish

As previously discussed, assumptions should be articulated and explicitly addressed in patient-surgeon communication; deeply held attitudes and beliefs about uncertain futures should, too. Surveyed cancer surgeons reported their most common ethical strivings were "providing patients with honest information without destroying hope" and "preserving patient choice."⁴⁸ Withholding honest (if not accurate) prognostic estimates, however, can deprive families of much-needed context and thwart planning, preventing families from focusing on what matters most to their loved one. Accuracy and realism are key features of trustworthy professionalism.^{49,50} In one study, 93% of 179 interviewed surrogate decision makers "felt that avoiding discussions about prognosis is an unacceptable way to maintain hope."⁵¹ **Honest prognostic estimates** also allow families a space for meaningful communication⁴⁵ (eg, saying goodbye and expressing love, gratitude, and forgiveness).⁵² Because *hope* and *wish*—like values, preferences, and goals—are commonly conflated concepts that are often used to describe the value-laden future orientations and expectations of surgeons, patients, and their loved ones, another set of working definitions could help facilitate clear, covenantal communication.

- *Hope* is a positive, empowering, transcendent attitude, which reveals the underpinnings of deep-meaning construction that are based on acceptance of *realistic* prognostication,^{32,53,54,55} no matter how foreboding.
- *Wishes* are distinctly more anxiety oriented and reality denying than hope, as they derive from imagined *unrealistic* outcomes or outcomes for which no feasible pathway exists.³²

False hopes—such as patients’ belief that if they die from surgery, they will do so peacefully in the operating room⁵⁶ or beliefs that death itself can somehow be defeated—are therefore better termed wishes. False beliefs and fantastical wishes⁵⁷ are commonly encountered in end-of-life scenarios—among both families⁵⁸ and surgeons^{9,12,13,16,59,60,61}—and might upend ethical collaborative communication processes,⁵⁷ particularly when grieving family members (and surgeons?) are asked to assess health information with realism and offer accurate preference-based substituted judgments.^{62,63,64} True hope, paradoxically, is not outcome based, but rather transcends outcomes, as it is the meaning-based substratum of one’s goals.^{32,53,55} As Balfour Mount, the father of palliative care states:

Hope is not the same as wishing. Hope is a perspective on reality, a point of view.... It reflects a degree of inner peace. *Hope* is a child of the human spirit. It arises from an experience of personal meaning. *Wishing*, however, arises from a sense of need, dissatisfaction and unrest. It reflects a sense of incompleteness. Hope is the product of adversity transcended, wishing of adversity denied.³²

A Word About Wants

We caution against clinicians inquiring about what patients *want*, since, in our experience and the experience of other palliative care communication experts,⁶⁵ this word prompts many patients and surrogates to think in terms of their wishes rather than in terms of their values, preferences, or realistic and meaningful goals. Value-congruent decisions require reflective—rather than reactive—thinking.^{1,20,46} Asking patients or surrogates whether they *want* surgery or *want* potentially value-discordant postoperative treatments, consistent with the “independent informed choice” communication style (what one noteworthy palliative care ethicist terms “radical autonomy”),⁴¹ can shift the decision-making power locus toward the patient^{41,48,65} even as it might invite the patient’s immediate—and possibly fear-based—dichotomous decision⁶⁵ rather than support the patient’s reflection and deliberation about values^{1,14,23,29,36,45,48,66,67,68} that can be expressed in a surgeon’s patient-centered actions.

Overall, we suggest that surgeons looking to establish and nourish covenantal communication with their patients, especially preoperatively but also in SICU settings, do the following: identify surrogates early; clearly explain to surrogates what substituted judgment is and promote it by eliciting and helping to clarify patient values and preferences with all 3 parties; and articulate value-congruent care pathway recommendations while deliberating about why alternative paths are value incongruent or fantastical, along the lines we have suggested here. To facilitate patient-centered surgical care and good end-of-life contingency planning, we also suggest inviting patients and their surrogates to imagine and articulate unacceptable levels of suffering and possible acceptable death process scenarios before patients are incapacitated with operative anesthesia, postoperative sedation, or delirium or before they lose the ability to express their values in nuanced terms (eg, after intubation), particularly in high-risk cases. Creating and maintaining actionable, value-congruent, feasible, patient-focused

action pathways is ethically and clinically necessary to making good on our covenants with those for whom we owe duties to care.

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