SURGICAL ETHICS CHALLENGES

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Is "your only hope" medical treatment choice really a choice?

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An elderly gentleman, from Scandinavia, Mr K. R. Plunk, with a soon-to-be lethal disease, has come to see you because you are the world's expert in complex aneurysm surgery and his is a case for the books. He has multiple comorbidities; the most concerning is his cardiopulmonary functioning. You have only operated on a few patients who are at this level of risk. He has been told repeatedly you are his only hope, which is literally true. A cure would pair one of the "biggest operations" with one of the frailest patients. You have been on an invincible roll and have decided to give it a shot, if he agrees. What is the most ethical informed consent in this case?

A. Standard informed consent is appropriate.
B. Ethically adequate informed consent cannot be given in this case.
C. Informed consent must include the possible long-term intensive care unit fears.
D. Consult your risk management group.
E. Emphasize realism and futility in informed consent.

Always give the patient hope, even when death seems at hand.

—Ambrose Paré

Informed consent has become an ethical mandate of medical practice that began as a surgical best practice, which was then shaped by common law and refined by bioethics. It is regularly believed that, before the modern era of informed consent beginning in the first third of the 20th century, surgeons told patients what was planned without much explanation or respect for the rights of patients. As early as the 17th century, however, British surgeons made contracts with clients, in the course of which information about the surgeons' role and—it is worth noting—the patients' roles were specified. In his 1772 *Lectures on the Duties and Qualifications of a Physician,* the Scottish physician-ethicist John Gregory may well have been the first to acknowledge patients' rights: "Every man has a right to speak where his life or his health is concerned."[1]

By the early 20th century, surgeons routinely obtained consent from their patients, a practice that was codified into common law by judges in such landmark cases as *Schloendorff v. Society of New York Hospital* in 1914. "Every human being of adult years and sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages . . . except in cases of emergency."[1,2] New scholarly analysis of the *Schloendorff* case has produced evidence from her admission record to the New York Hospital that she did indeed consent for surgery.[2]

A century ago this year, the *Schloendorff* court mandated simple consent. Simple consent involves one question, "Did the patient agree to be treated?" The patient's simple yes or no determined whether the surgeon could operate. In subsequent court cases, the concept of informed consent developed and the question became: Was the patient (or the patient's surrogate decision maker) provided with enough information to result in saying yes or no as a meaningful exercise of individual self-determination? *Canterbury v. Spence,* from 1972, for example, concerned consent to repair a ruptured disc. Dr Spence obtained simple consent from Mr Canterbury's (a minor) mother. Dr Spence was asked about potential risks and replied that a laminectomy held no more risk than other procedures. The patient then suffered paralysis from a postoperative fall and sued. The court decided the surgeon must inform in nontechnical terms, "the therapy alternatives open to him, the goals expected to be obtained, and the risks that may ensue from a particular treatment and no treatment…."[3]

Bioethics refined the process of informed consent, identifying the several steps that require completion. The surgeon must disclose adequate, clear information,

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commensurate with the intelligence and emotional status of the patient and family, about the patient's diagnosis and its surgical management, the disease process' undesirable outcomes warranting intervention, alternative therapies, and the possible complications and their likelihood. Because every surgeon performing major visceral procedures has had patients die when it was thought they would live and live when it was considered they would die, the point should be made—without "crepe hanging"—that there are no guarantees regarding major operations.[4]

Thus, meaningful informed consent requires relevant facts regarding care choices. Informed consent is, perhaps, the most significant and the most deliberated ethical breakthrough since medical ethics emerged.

Modern informed consent has several components: the natural history of the disease process if nothing is done sets the stage for the risk/benefit discussion of therapy. Nothing to be done is the most underexplained element of informed consent. All medically reasonable therapies (technically possible and expected to result in clinical benefit) should be explained. When deliberative judgment supports one of several medically reasonable alternatives as clinically superior or when there is only one medically reasonable alternative, the surgeon should recommend that therapy. The surgeon should offer to help the patient to think through the medically reasonable alternatives.

Hope is a powerful defense mechanism and often grows larger as medical conditions worsen. Hope has two components: the desire for a future state of affairs (hope object), the probability of which is greater than zero and less than one, and the intensity of that desire. When the probability of attaining the hope object is zero, hope becomes false hope. The intensity of the desire for the hope object is independent of its probability; a patient or patient's family, therefore, can rationally desire a hope object with far more intensity than the degree of its probability.

Saying to a patient "this is your only hope" situation is the ultimate challenge. A surgeon should not do so when the probability of survival with at least some interactive capacity is near zero. The professionally responsibly surgeon must be alert to the allures of self-deception in such circumstances. The riskier the treatment, the more likely death is the outcome, but when faced with certain death, risky odds become favorable. Modern surgical technology, when applied in the attempt to save, can make dying much longer, costly, and painful, especially for the relatives.

Should the conscientious surgeon be concerned that "this is your only hope" situation could influence the decision-making process to such an extent as to invalidate the informed consent process? The answer is "no." Rational hope, no matter how intense, does not render a patient unable to engage meaningfully in the informed consent process.

The informed consent process with "big surgery" that is seen as the patient's "only hope" needs to emphasize not only mortality and major complications but also the chance of prolonged life support.[5] In cases like Mr Plunk's, as the complexity and uncertainty of the outcome increase, the patient should be aware of all possibilities; "big surgery" that goes south can become a prolonged battle with the Reaper. Patients' outcomes under those circumstances can considerably stress the patient, family, and finances. For the patient to exercise his or her autonomy in the informed consent process for "your only hope" cases, the probability of a demanding postoperative course must be mentioned. A recent study of informed consent in such cases found this aspect often was omitted.[5] Including a full disclosure of a prolonged intensive care unit stay allows a sensible autonomous decision and the formation of rational hope.

Autonomy and beneficence are at odds when distressing information is withheld. "Truth telling [in grim cases] should be regarded as a process through which the truth is developed and revealed progressively, sensitively, and skillfully to help patients understand and live with their illness, while maintaining a strong sense of hope."[6] Standard disclosure when in unfamiliar dangerous clinical territory is inadequate; these patients want to avoid the Reaper at all costs. The possible costs must be described in detail.

Option A is not acceptable because, as mentioned, it does not prevent false hope. A responsible informed consent requires the complete picture of how über-cases have a higher chance of unfortunately playing out.

Option B is nihilistic in its false assumption that hope is always incompatible with the meaningful exercise of autonomy in the informed consent process.

Risk management is a product of litigation proliferation and has no role in the determination of case selection. Option D is therefore not acceptable.

The need to set limits on postoperative surgical intensive care is a very real probability. It should be discussed, as part of Option C, but emphasizing it, as called for by Option E, may not promote the meaningful exercise of patient autonomy. Option C should be implemented, alert to the emergence of and the professional responsibility to prevent false hope. Balancing one's procedural abilities against combatting a patient's diseases is one of the most challenging and either rewarding or chastising experiences in surgery. There is no comparable occupation where so much is daily on the line.

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