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Opinion

Patient-Centered Decision-Making in Surgery And Anesthesia: Collaboration For Better Patient Care

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Introduction

Referrals from the surgical ward to the intensive care unit run by anesthesiologists can sometimes give a clash between surgeons and anesthesiologists in daily clinical practice. In patients with severe comorbidities there may also be disagreements before surgical procedures regarding indication for surgery. These are clinical dilemmas in the crossroad between anesthesia and surgery, and in the literature, it is often discussed under the term "futility of care".

The concept of medical futility was not discussed in the medical literature before the 1980'ies [1], but the interest in the medical literature has decreased in recent years [2]. It is relevant to discuss not only for ethical reasons but also in times of cost containment. We all want to do no harm but also to utilize health care resources reasonably.

The area is, however, quite problematic, as there is in many cases no clear definition or even understanding of futility. Different stakeholders such as the patient, surgeon, anesthesiologist, and family members may view questions of futility differently [3], and even among physicians (intensivists) [4] and nurses [5] there is variation. Nevertheless, the clinical problem is real as caregivers say that provision of futile care occurs in daily clinical practice [6].

A literature review found that decisions to withhold or withdraw a futile measure was done often after a dialogue with the patient but also sometimes without informing the patient at all or with just one-way information from caregiver to patient [7]. This certainly points in the direction of an important clinical problem where patient involvement could be improved.

Anesthetists and surgeons have the same goal and that is of course to do no harm and to secure the best possible outcome for the patient. There are, however, disagreements in daily clinical practice and it typically involves one or more of these issues: 1) Who is involved in the decision, 2) who is actually in charge if there is disagreement, and 3) the decision by caregivers to say no to surgery or no to referral to the intensive care unit is often based on anticipated low quality of life for the patient if lifesaving surgery or intensive care is performed.

Discussion

The Society of Critical Care Medicine Ethics Committee in the US has stated that "ICU interventions should generally be considered inappropriate when there is no reasonable expectation that the patient will improve sufficiently to survive outside the acute care setting, or when there is no reasonable expectation that the patient's neurologic function will improve sufficiently to allow the patient to perceive the benefits of treatment" [8]. This seems reasonable also for surgeons and family members, since nobody wants the patient to go through a period in intensive care resulting in death or severe neurologic deficit at a level where he/she will not be aware if he/she is alive afterwards. The problem arises in cases where an operation with its complications or a treatment period in intensive care will result in a situation with severe disability but where the patient is aware of the surroundings and can have emotions towards family and friends [8]. These situations occur in the clinical setting, and it is exactly these situations that are difficult to handle for caregivers and family members.

It is worrying that decisions against acute interventions or admission to the intensive care unit sometimes are taken without involving the patient and/or family members. The surgeon will typically be more aggressive than the anesthesiologist for interventions and even intensive care, and this may sometimes

give disagreements. Anesthetists are experts in judging the risk of anesthesia and if the patient may die on the table. The surgeon has less expertise here. However, surgeons have knowledge on the long-term natural history of the disease with and without treatment as well as risks of infectious complications and other surgical related complications including risk of in-hospital death. In most countries outside North America intensive care is taken care of by anesthetists, and expertise on chance of survival and acceptable outcome in this setting thereby belongs to the anesthetists. In settings where intensive care is run by the surgeons it may be the opposite situation. Thus, there is different expertise between specialties that will contribute to the discussion, and a consensus decision is therefore of course the best - with mutual respect.

There is, however, still a major problem. How do the attending surgeon or anesthetist actually know anything about quality of life after surgery for the specific patient? This is based on the caregiver's own belief and not on the actual patient's quality of life postoperatively. Nobody knows if the patient would prefer to be alive or dead given a certain quality of life. Who can judge if the patient would prefer to be alive although maybe bound to a wheelchair, if he or she can see the grandchildren once a month? Who can judge that preoperatively? The best to judge it would of course be the patient and maybe family members - not the surgeon nor the anesthetist. Predicting what life will be like for a patient after surgery is like trying to guess the ending of a movie you've never seen. Surgeons and anesthetists often must make tough calls based on what they think will happen, but nobody really knows for sure what the patient would want. It's like trying to figure out if someone would rather be alive with a few challenges or not alive at all. The best person to decide this is the patient, but it's tough to know their preference before the surgery. Anesthetists usually don't see patients after a long time, so they might not fully understand the whole picture. Surgeons sometimes do, but deciding someone's quality of life is hard, especially in the middle of a rushed surgery or an emergency in the ward. So, the challenge is finding a way to include the patient's voice in these decisions, even when time is short, and the situation is tense.

Can the surgeon, the patient, or a family member overrule the anesthetist and demand that the procedure is done or that the patient is transferred to the intensive care unit? Most often not, but there may be serious conflicts because the hierarchy is not established officially, and this is not to the patient's benefit. Consensus will always be the best option, but when there is disagreement, it is important to have a well-defined chain of command. This goes for all job situations and in all jobs on the planet, but it is especially important in situations where decisions may result in life or death. Fortunately, in many cases these decisions of whether to go through a surgical procedure or offer intensive care are performed without major problems, and intense collaboration and mutual respect between all stakeholders (patient, family, surgeon, and anesthetist) will facilitate the process. The importance of surgeon-anesthetist collaboration [9] as well as timely involvement of patient and family members teach us valuable lessons about teamwork, communication, and understanding. By uncovering these issues, we can smooth the path for better patient care and foster a more united and effective healthcare team.

Solutions

It would be optimal if we can resolve potential conflicts over futile treatment in advance. In my country we have issued a law where patients can make a "living will" that is registered officially and will be visible for the caregivers if the patient becomes life threatening ill [10]. In the living will, the patient has made a decision about whether he/she wants life-prolonging treatment if he/she is dying, and there is no chance that it will change, or if he/she due to severe disability, is permanently unable to take care of him/herself physically and mentally. This serves as a treatment directive to ensure that doctors follow your wishes if you are on the verge of death and unable to communicate. Even though it implies serious thoughts and possible discussions with friends and families it is straight forward in the elective setting.

The problem arises in the acute setting where the patient may be mentally incapacitated because of the acute illness. Disputes over futility in the acute situation is quite terrible for all stakeholders. Here it seems obvious that no one should make the decision to continue or increase treatment or the opposite by themselves. Each person involved has important contributions to the discussion. The family member will be able to explain the level of activity and cerebral capacity of the patient during daily life and also to explain the wishes from the patient even though he or she has not made a living will. The surgeon will contribute with knowledge about the natural course of the surgical condition with or without treatment, meaning the prognosis in the current situation based on the physical condition and severity of the disease. The anesthesiologist will have, as the only one in the care team, profound knowledge of short-term outcome of intensive care treatment. However, many intensivists do not see the patients after long-term follow-up so they do not have knowledge about quality of life and function levels of these patients months after intensive care. This long-term follow-up is typically performed by the referring physicians/surgeons, family doctors, and family members and these data are not systematically available for the intensivists.

A new study has shown that futility after emergency laparotomy in many cases can be quantified using preoperatively available risk factors [11]. This study and many alike focused on the physical condition and physical complications whereas quality of life measures have not been in focus. This is a major problem in much of the available literature since it is unwise for healthcare professionals to focus on physical conditions without the psychological and quality of life issues. Who can decide between life and death if a patient prefers to be physically or even mentally disabled but preserving important quality of life measures anyway? This is exactly why the patient and in the acute setting certainly also the family members should be involved with a significant vote in the decision-making process.

Conclusion

The anesthesiologist may be seen as a service provider, a consultant, or a gatekeeper [12]. This is, however, the same position for the surgeon, and there is no shame in fulfilling either of these roles. In the eyes of the patient and also the family members we are often seen as service providers but when complications occur and especially in the life-threatening acute situation both surgeons and

anesthesiologists should be seen more as consultants in the mutual decision-making process. Even though it is part of our responsibility as professionals to serve to some extent as gatekeepers to not waste healthcare resources, in the acute situation it is actually a very difficult position. We have hospital management and politicians (in socialized healthcare systems) that will focus on the gatekeeper responsibility, but in the acute situation I would suggest that this should receive lesser attention compared to the consultant roles as experts in surgery and anesthesia looking at physical and mental prognosis for the patient in the given situation. This is of course controversial and is not an all or none phenomenon.

The issues of futility in acute and intensive care are important for daily clinical practice caring for severely ill patients. Collaboration between surgeons and anesthetists is extremely important and we should all strive to move in the direction of better collaboration [9,13,14]. The challenges underscore the need for a collaborative and respectful approach between all stakeholders (patient, family members, surgeon, and anesthetist). Navigating disagreements requires more than just finding a boss; it calls for a shared understanding of roles and a commitment to clear communication. The uncertainty in predicting postoperative quality of life highlights the importance of including the patient's voice in decisions, even during urgent situations, and if the patient cannot communicate then family members get a vital role. Recognizing the distinct expertise each side brings to the table becomes paramount for effective collaboration. In the end, it's not about who has the final say but about finding common ground rooted in respect for each other's skills and a shared dedication to the patient's well-being. Through mutual respect and collaboration, the surgeon-anesthetist partnership can evolve into a seamless coordination, ensuring the best possible outcomes for the patient.

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Conflict of interest

No conflict of interest.

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