VIEWPOINT

Innovations in Surgical Communication 5—When Surgery Is a Bad Idea, Focus on the Goals

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"I want it out," she said. The slowly growing suspicious nodule found incidentally prompted many to tell her that she needed surgery. Yet, in comparison with her overall failing health, early-stage cancer was not life limiting, even if left untreated. Over the past year, she had been hospitalized frequently for issues related to heart and lung disease. She had good days but spent much of her time sleeping. It was implausible that she would survive more than a few weeks after the physiologic insult of surgery. But, telling her surgery was too risky was unconvincing, as she noted, "there's a risk to everything."

There are multiple variations of this conversation where our judgment that operating is a bad idea conflicts with the patient's desire for surgery. From the patient's standpoint, surgery makes sense. They worry about incidental findings or hope for pain relief, improvements in function, or reversal of a life-limiting diagnosis. Before the surgical consultation, others—clinicians, family, friends, social media, and online sources—have primed the patient to believe that surgery can solve their problem.

Despite our concerns that surgery will not realize the patient's goals, we unintentionally reinforce the narrative that surgery is the solution to their problem. Traditional models of consent suggest that patients need to understand their disease and treatment[1]; thus, we show scans, discuss anatomical nuance, and describe in detail technical difficulties that the operation presents. Although we aim to send a message that surgery is a bad idea, our story about the patient's problem and its corresponding operation sends a different message: this is a technical problem that a good surgeon can fix.

To further counterbalance the patient's expectations, we accentuate risks and complications without explicitly disclosing our assessment that their goal for surgery is not attainable or is highly unlikely to occur. To support the ideals of shared decision-making, we offer surgery as a choice as if we are neutral about its value and use strong language about risks to implicitly push the patient toward an alternate plan.[2] This attempt to dissuade them erodes trust. Although surgery is unlikely to help the patient, they believe their only choice is to take on the risks of surgery and we resign ourselves to operate, noting "it's their decision." When anticipated unwanted outcomes arise, patients and families are upset, and we are frustrated by foreseeable events.

Rather than pretend we are impartial, we should state our worry about reaching the patient's goal from the start. Using the framework that we described previously,[3] we can use the 4 goals of surgery (live longer, feel better, prevent a disability, and make a diagnosis) to express our concern that surgery is not a solution to the patient's problem. Consider the contexts in which this strategy can be used.

Surgery Cannot Meet the Goal

There are some patients for whom we will not operate under any circumstance because, with certainty, achieving the goal of surgery is implausible or extremely short lived (eg, the aforementioned patient with cancer). Rather than saying, "you aren't a surgical candidate" or "it's too risky," we can note our shared goal to help the patient live longer and our disappointment that surgery will not meet this goal. This reframing is necessary when surgery is antithetical to the goal because it would shorten life or when surgery cannot plausibly help patients feel better or preserve function. There are also patients for whom the goal can only be met for a very short time (eg, a current smoker with class III obesity and a symptomatic ventral hernia). Even if the factors precluding surgery are modifiable in the future, we should not pretend to deliberate about surgery because we are not offering surgery now. Instead, we can endorse our shared goal—that we want them to feel better—and express disappointment that surgery will not meet this goal: "I wish surgery could do that."[4]

Reaching the Goal of Surgery Is Unlikely

Sometimes there is enough uncertainty about whether the goal of surgery is attainable that we might operate despite our unease. We can navigate this uncertainty by naming 1 of the 4 goals and describing what it might be like to experience its downsides (having surgery, recovery, a chance of complications, and falling short of the goals).[5] Consider a patient with varicose veins and atypical pain. Surgery is unlikely to help them feel better; thus, it is a lot to go through without achieving the goal. Yet, sometimes we are wrong; some patients with atypical pain feel better. We can say that we do not think surgery will help the patient and then deliberate with them about what to do: "Given my concerns, how do you feel about going through surgery with only a small chance of reaching your goal?" If the patient understands that the primary goal of surgery is to help them feel better (and we verify they have not mistakenly attributed a different goal, like life or limb preservation) and they confirm that they would tolerate the experience of surgery even if it falls short, we should operate and hope along with the patient that their pain improves. This setup is useful for many patients with chronic pain and nonspecific imaging findings (eg, findings related to the gallbladder, median arcuate ligament, or thoracic outlet).

Surgery Can Meet the Goal Yet Will Likely Leave the Patient Worse Off

While we have improved our estimates about who will do poorly, we are apprehensive about operating on patients with frailty because achieving the otherwise plausible goal of surgery is greatly reduced by their body's ability to tolerate it. We can express our worry

that the trade-offs between the surgical goal and the downsides might be devastating. In our efforts to help patients feel better or prolong life, they are likely to experience a serious functional decline or die. Given the uncertainty, if the goal is plausible and they are willing to take on these burdens, we can support their preferences and hope for a good outcome.

Some will argue that revealing our opinion is overly paternalistic. Yet, we already do this in ways that are less sincere by trying to contort our expertise into a shared decision-making framework that prioritizes promoting options over understanding context. We argue for generating trust through transparency by reframing the conversation,[6] shifting the conversation from a technical fix toward a discussion of whether surgery could reach the patient's goal and how it would affect their life. Offering an explicit expression of concern that surgery is a bad idea based on our expertise, followed by a clear articulation of the goals and downsides, will allow us to deliberate with patients about what we might plausibly accomplish and what patients might tolerate given the unknowns. Some patients will disagree with our reasoning, believing despite major downsides that it is worth the small chance that surgery will prolong their life or reduce their pain, and we should support these preferences.

Good decision-making does not entail hiding a professional opinion; it requires engaging in genuine deliberation with a patient based on what is plausible, valuable, and tolerable for them. These conversations will never be easy, but our current practices make these interactions harder. A better conversation will allow us to communicate our concerns, navigate uncertainty based on expertise instead of misunderstanding, and identify patients whose tolerance for unwanted outcomes may be stronger than our own.

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