VIEWPOINT

Innovations in Surgical Communication 3—Promote Deliberation, Not Technical Education

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Imagine you live in an old house with tenuous plumbing. Your toilet isn't functioning well, so you call a plumber. After looking it over, he talks about what to do. He describes the different parts of the toilet and draws a diagram. He proceeds with a long discussion about the tank lever, flush valve, fill valve, seals, and flapper and explains how the tank is sealed to the bowl with a tank-to-bowl gasket and 2 tank bolts. This all works through a series of delights in fluid mechanics. He notes that the gasket is leaking and describes with precise detail how, after emptying the tank and removing it, he can take the gasket off and replace it and the tank bolts and their gaskets. After this 20-minute explanation, he notes that the total cost is $300 and asks what questions you might have.

Overwhelmed, you ponder what to do. It's costly, but the plumber seems kind and knowledgeable. Your toilet has a problem; he has a procedure to fix it. It feels right, but you lack the critical information needed to decide if it is worth it, despite the detailed description of toilet parts and fluid mechanics. You have an old house and an old toilet that will need to work in concert with the new gasket. How well will the toilet work? How long will the repair last? Are there downsides to replacing the leaking part now that will cost you more later? Assuming the plumber's technical knowledge and the promise the prob-lem will be fixed have not distracted from your concerns, you can ask these questions, but shouldn't the plumber have started with these key points? Although you can't verify his expertise, the plumber sounds qualified. Yet he hasn't helped you figure out what is right for this toilet in this old house.

Professionals in our lives help us make decisions—often with real consequence or expense—in a field we know little about. Many people have some familiarity with plumbing, car mechanics, financial planning, or legal procedures. Still, we outsource our need for specialized knowledge, experience, and judgment to others because of the complexity of our world. We seek their competence and skill to support us as we navigate a particular problem. In consultation, we need them to distill their training and experience to help us lay the course, not slay us with their intelligence or teach us technical facts.

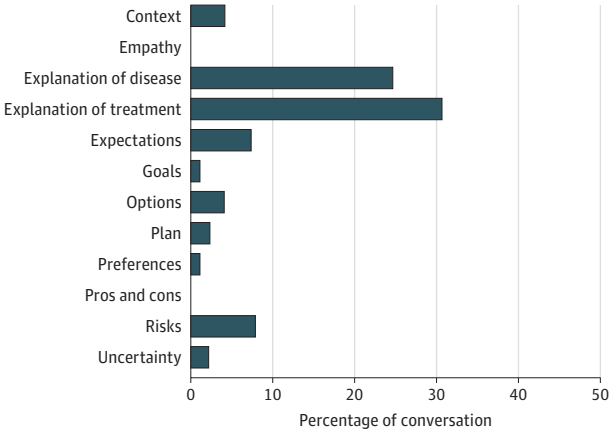
Like your disorientation with the technicalities of the broken toilet, it is not surprising that patients and families are waylaid during discussions about surgery and blindsided by their postoperative course even when everything goes well. When we recorded audio of surgeons talking to patients about major surgery, we found that more than 50% of the decision-making conversation was consumed with meticulous description of the patient's disease and the operation suitable to treat it (**Figure**).[1] Surgeons teach patients to interpret images such as computed tomography scans. They say, "This is you, sliced like bread," showing pathology represented in the pictures before them. These conversations could support a mini-medical school, eg, "The esophagus has 3 layers, the mucosa, the submucosa, and the muscularis." They say, "There is stage 1A, 1B, 2A, 2B, 3A, 3B, 3A, 3B, 3C, 4A, and 4B," and include intricate details about surgical technique. For example, "I will use a continuous suture to sew your urethra to your bladder."

Surgeons act as though transparency about their clinical reasoning and surgical technique will allow the uninitiated to think like an expert and make the right personal choice. Knowledge is power, but the notion that hierarchical relationships can be mitigated by providing reams of medical information is flawed. While this pattern likely reflects a desire to support autonomy or somehow meet criteria for informed consent, it is not possible to transfer deep knowledge gained through years of training and experience. It is hard to imagine that patients could learn enough about anatomy, pathology, and surgery to make their own assessment about whether an operation is a good idea.

Does knowing how the plumber will fix the toilet help you figure out if it is worth repairing? Like the plumber's speech, surgical consultations showcase the surgeon's knowledge, but this content is not useful for decision-making. To help the homeowner decide, the plumber needs to know how the homeowner is thinking about this toilet. Do they need a short-term solution? Do they have a longer-term strategy to remodel the bathroom? Do they loathe spending money now when they will need to revise it later? Instead of addressing information asymmetry with technical knowledge (or persuading us with their erudition), professionals should coach us (as clients, customers, patients) in deliberation. Those who do this well help us clarify our needs, our longer-term vision, and how we consider these items in comparison with what we can tolerate or afford.

Surgeons need to step back from descriptions of disease, avoid showing images, and put down the illustrations. A better surgical consultation explains what surgery can achieve for the patient. Will it help them live longer, feel better, or

Figure. Content of Communication in Surgical Consultations



The content of consultations between 43 surgeons and 169 patients at 5 clinical sites is represented.[1] The median percentage for empathy and pros and cons was 0, although 21% and 50% of transcripts had at least 1 mention of empathy and pros and cons, respectively.

prevent disability? How much longer might they live? How much better could they feel? By engaging in a conversation about what surgery might accomplish, instead of the mechanics of how surgery is done, surgeons can build rapport with patients to consider whether their goals are plausible and whether surgery is worth its attendant downsides, eg, pain, recovery, and a chance of complications.

Some surgeons will say they lack the time for this conversation, yet they will spend half their consultation talking about pathophysiology and surgical technique. These efforts are time-consuming and ineffectual. A judicious use of limited consultation time focuses on the goals of surgery and patient expectations. Once a surgical plan is in place, there are opportunities to engage with curious patients about the technical details of surgery. Because the aim of surgical consultations is to determine whether surgery is right for the unique patient who has come to see you, squandering precious time on information that is confusing, difficult to retain, and not actually helpful for generating consensus about treatment is a practice surgeons should reconsider.

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1. Stalter LN, Baggett ND, Hanlon BM, et al. Identifying patterns in preoperative communication about high-risk surgical intervention: a secondary analysis of a randomized clinical trial. *Med Decis Making*. 2023;43(4):487-497. doi:10.1177/0272989X231164142