VIEWPOINT

Innovations in Surgical Communication—Provide Your Opinion, Don't Hide It

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How should surgeons talk to patients and families when we feel strongly about what should be done? A recent study from our laboratory[1] found that surgeons are more likely to perform well on measures of shared decision-making when they are reluctant to operate. When patients had prohibitive comorbidities, when there were clearly safer alternatives, or when the diagnosis was not amenable to surgery, surgeons presented surgery as 1 of 2 treatment options and discussed the pros and cons of each. Much of the remaining consultation was used to delicately talk the patient out of surgery. For example, we observed an 87-year-old patient with bladder cancer considering cystectomy with a complication rate of 40% to 60%. The surgeon noted this operation had been done successfully on an 85-year-old patient, but the patient was exceptional, "[He] was, like, hiking Everest."

In some settings, we are direct. We simply do not offer hospice as an alternative to colectomy for a healthy patient with early-stage colon cancer. In other settings, we act neutral despite our strong opinion surgery is beneficial[2] or propose surgery as if it were a reasonable option when it is not. Supporting patient self-determination seems to require presenting choices and acting as if we are impartial about how to help. But does presenting untenable options or hiding our judgment really support autonomy?

When there is more than 1 reasonable option, offering patients choices is necessary to support autonomy and select the right treatment. Offering untenable options or withholding our judgment supports neither of these objectives when surgery is clearly beneficial and when we firmly believe it will produce more harm than good. Yet we frequently find ourselves in a difficult conversation because we have concealed our opinion or offered treatment that does not make sense.

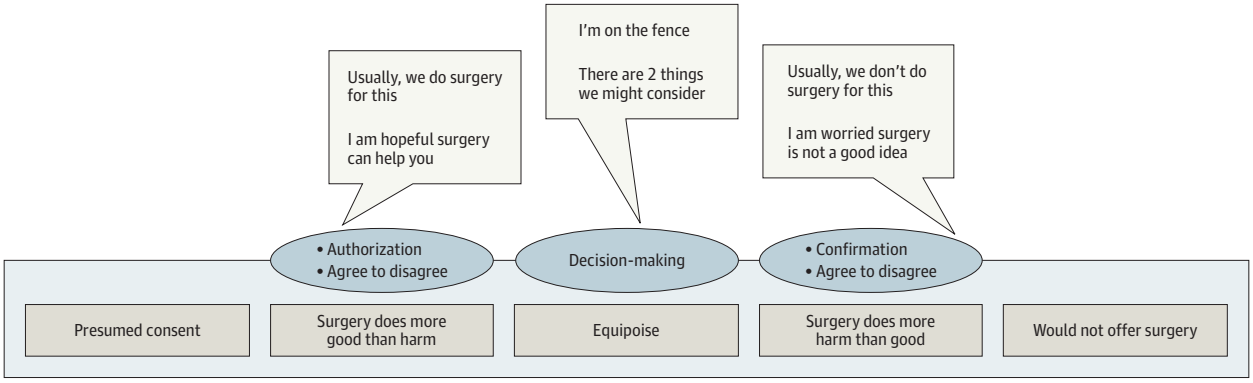
Withholding judgment and offering choices likely stems from surgeons' good intentions: to support a range of values in a pluralistic society. But holding our cards close to the chest does not promote autonomy. In essence, we give the patient a nonchoice choice[3] and adopt a position of neutrality as a stand-in for targeted deliberation or delivery of bad news. It is hard enough for patients to manage a major treatment decision without having to guess what is usually done or what their surgeon considers their best interest. It is misleading to set them up and, without transparency, push patients and families to "make the right choice." Furthermore, it is burdensome for families to shoulder responsibility for a "decision," especially for a dying patient, because clinicians have concealed their thinking. When patients or family choose to pursue nonbeneficial surgery, we hold them responsible for being unreasonable, noting in conversations with other clinicians that we are operating because "they want everything."[4]

A better model would show our cards upfront to provide context; to disclose this is where I, your surgeon, am starting from. We might say, "Typically, we do surgery for this" or "I'm worried surgery is not a good idea" (**Figure**). By setting the stage, we can orient patients and families to our professional thinking before considering the trade-offs between what surgery might accomplish and its downsides. This strategy is helpful because it provides a reference for patients and families as to "what is usually done." People in an unfamiliar situation often value and want to know what others would do when faced with similar difficulties.[5] This initial point of reference can also alert patients and families to conditions of equipoise or when we are truly unsure about how to help so they can recognize the need to engage. Saying, "I'm on the fence; there are 2 things we might consider" can position the moment as a decision about 1 of 2 reasonable treatments or the need to select the least-worst option.

Normalizing one treatment does not bar an alternative path. Once we have shown our cards, we can present our reasoning about whether the goals of surgery are worth its downsides. As we describe what surgery might accomplish and what it might be like to go through it, we can check in and confirm that our initial assessment—where we placed our cards—is correct from the patient's view. For those who go on to have surgery, these considerations are required for their authorization to proceed and will help them anticipate and prepare for an often-painful experience. When we think surgery is unlikely to meet the patient's goals, we need to confirm they agree with our reluctance to operate or discover they find our reasoning unsatisfactory.

Revealing our thinking does not preclude identifying patients who are outliers—those who might value a different strategy or disagree that what is usually done is right for them. After deliberation, some might conclude surgery is too hard, or the goal is not valuable to them. For example, older adults often prefer to forgo life-prolonging treatments because of serious trade-offs in functional status.[6] Although surgeons might worry that the patient will be worse off without surgery, we can agree to disagree and support an alternative as a reflection of their priorities. Conversely, when we are reluctant to operate because the likelihood of achieving the patient's goal is low, we can reconsider our initial inclination relative to what they are hoping to achieve. An agreement to disagree allows surgeons to respect the patient's desire for self-determination and admit to uncertainty about whether surgery will make the patient better off.

Figure. The Range of Surgical Decisions



The context of surgical treatment ranges from settings in which surgery is always done (ie, presumed consent) to where surgery is not offered. On the left are cases for which surgery is clearly the accepted treatment and usually does more good than harm. On the right are cases where surgery is not often done, or is done with reluctance, because it usually does more harm than good. At the center of the continuum is equipoise, where 2 reasonable treatments exist.

Some may worry that the surgeon-patient power dynamic will prevent patients from expressing an alternate view, leaving consequential decisions overly susceptible to the surgeon's judgment. No doubt, surgical reasoning can be erroneous, vulnerable to incentives and biases. This is a problem for the profession; it is not the responsibility of patients and families to remediate surgeon bias by making better choices when they are scared and sick. Withholding judgment and presenting untenable options are not solutions to flawed clinical reasoning, and they have the added hazard of hiding important knowledge. A better strategy would start with transparency. We can reveal our initial impressions and move forward in a space of deliberation to consider whether our inclinations make sense for this patient.

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