Perioperative Ethical Issues

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KEYWORDS

• Shared decision-making • Do Not Resuscitate • Medical ethics
• Affordable Care Act • Operating room

KEY POINTS

- Shared decision-making is an important emerging paradigm in clinical medicine.
- Physicians must respect the basic tenets of patient autonomy and present options to patients without regard to incentivization.
- Shared decision-making can be useful in the preoperative evaluation of higher-risk surgical candidates.
- Do-Not-Resuscitate (DNR) orders should be evaluated on a case-by-case basis. There should be no uniform suspension of orders for the Operating Room.
- Preoperative discussion about DNR should be initiated as early as possible.

SHARED DECISION-MAKING

Introduction

Shared decision-making (SDM) is an emerging paradigm in medical ethics. It involves the reconciliation of 2 views: (1) the physician as the medical expert, and (2) the patient, with their individual values and viewpoints about present and future medical therapies. Despite its increased acceptance, SDM is hardly new. Several ancient cultures accepted and practiced this, including India and Japan.[1,2] In the United States, SDM was introduced in 1998, in the Presidential Advisory on Consumer Quality in the Healthcare Industry. Although definitions have some variability, Charles and colleagues[3] suggested the key characteristics should include the following: (1) that at least 2 participants, the patient and physician, are involved; (2) that both parties share information; (3) that both parties take steps to build a consensus about preferred treatment; and (4) that an agreement is reached on treatment to implement.

There is some disagreement on this definition, that is, that there can be an agreement to disagree.[4] The same investigators, however, also note shrinking consultation

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times and external pressures may have led to a decrease in patient engagement in the SDM process. A recent Cochrane study attempted to elucidate the value of SDM in the clinical setting; however, it was found lacking in high-grade evidence.[5]

Ethical Issues

As noted previously, SDM attempts to reconcile 2 views that are sometimes diametrically opposed and sometimes aligned. Physicians (and all health care professionals by default) are under the obligation to provide treatment for the benefit of the patient, known as beneficence. They are also obligated to not provide treatment that may harm a patient or may cause the least possible harm out of all possible alternatives, known as nonmaleficence. Using these 2 synonymous ethical guiding principles, physicians use a rubric called "best judgment" or "best practice" in order to offer optimal therapy to the patient. Patients, however, may have very different perceptions of the offered treatment. This viewpoint is fashioned by a variety of factors, including social, linguistic, cultural, and religious practice.[6] The patient's right to their health care decision-making without undue influence or coercion from their provider is known as patient autonomy. The crux of medical ethics with regards to SDM is whether ambiguous or reduced patient engagement reduces patient autonomy.

The uncertainty of patient autonomy led the legal community to obtain informed consent. Although a detailed discussion of informed consent is beyond the scope of this article, most states use 1 of 3 standards: (1) the reasonable physician standard, (2) the reasonable patient standard, and (3) the subjective standard. The first 2 are more intuitive, that is, stating what a similar physician or patient would want to know under a similar set of circumstances. The subjective standard is more complex, because it requires the physician to tailor the consent to the individual patient.[7] Several authors have attempted to elucidate this standard, by creating risk and certainty axes.[8] The higher the risk and the higher the uncertainty, the more detailed the consent. The converse is also true: with lower risk and only one viable option, the consent process can be simpler.

One routinely overlooked phenomenon is not the patient value axis, but the physician incentive axis. There are egregious differences in procedure reimbursement all over the country, and there are abundant data to indicate that physician recommendation is at least partly aligned with this incentive.[9] Although there is no governing body that scrutinizes this issue purely outside of the ethical issues, the Centers for Medicare and Medicaid Services (CMS) recently released a list of physicians who receive the highest reimbursement. All data can be accessed by the public on their website.[7] CMS has hoped that with this transparency physicians can better align themselves to their patients' values without being tied to adverse incentivization.

Affordable Care Act

Section 3506 of the Affordable Care Act mandates that the Department of Health and Human Services establish an independent entity to formulate and implement standards for educational tools for "preference-sensitive" patient care needs. In essence, this mandates gubernatorial funding entities to assist and fund decision-making tools to help patients understand interventions with regard to cost and evidence base.[10] To date, this program has been appropriated and not funded. Regardless, it represents a greater shift toward a model of consumer-based pricing, which is probably the way of the future.[11]

Evidence for Shared Decision-Making Preoperatively

The evidence for SDM is robust in some areas and indeterminate in others. A systematic *Cochrane Review* in 2011 analyzed the effect of SDM in 31 studies. Decision aids