Surgical Ethics – Theory, Philosophy, Background

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What does it mean for a practicing surgeon to be 'ethical'?

Consider the intentions and the struggles of a young surgeon in her first years of practice after residency. (Brown 2009) Let's call her Stephanie. Stephanie is the youngest and newest member of a team of surgeons whose practice is administered by a for-profit management company. She joined this practice with the assurance she would be fully supported in her deeply-rooted resolve to care for her patients in the most beneficial and cost-effective way, with special attention to socio-economically disadvantaged patients. She quickly discovers that numerous competing interests and expectations – some professional, others personal – pressure her to shift her focus away from her patients and their interests.

Stephanie begins most days poised to be empathetic. She is prepared to give disproportionate attention to her more vulnerable patients. She is ready to open herself to her patients' suffering to the point of risking burnout. She intends to be meaningfully present with her patients. She grips firmly her integrity. She gauges her capacity to tolerate the moral dissonance she experiences from value clashes with some of her patients. She seeks to grow professionally for patient benefit as much as for personal security. She feels a nagging tension between her lifestyle interests and her accountability to her patients.

Stephanie would violate her integrity if she refused to look beyond each patient's presenting problem. She has already seen far too much. However, she accepts that she is not yet one of those rare surgeons who seem capable of saying "yes" to every deeply pained patient and enter yet another broken story. Fatigue, accountability to her other patients, administrative obligations, family responsibilities, reimbursement pressures, personal interests apart from medicine, and a host of other considerations force her to limit many patients' access to her time, her energy, her heart. Instead, Stephanie triages her patients carefully to sift out the encounters in which she will enter more deeply into the patient's story, in which she will make and impose on others the sacrifices to be fully present with the patient.

Especially on her most exhausting days, Stephanie might glance enviously toward the many flourishing surgeons for whom the medical environment is most fertile. For these surgeons, a patient encounter is a sale; the patient, a consumer. Some are entrepreneurs. Lifestyle incentives motivate them. Others are researchers. Innovation and publication motivate them. They subtly sift out difficult patients from their panel of patients. They stay sufficiently detached from patient suffering to avoid any risk of being burned out. They have learned to make patients think they are present and care. They turn professional advancements into marketing tools. They lead unreflective lives. They have an easy conscience. But Stephanie is not seriously tempted to join their number.

However, Stephanie is troubled by how often she ends the day wearily thinking of the next patient as one more demand; thinking of herself as a mechanic. She ends many days numb toward patients and tired of confronting the healthcare delivery system. She feels acutely the loss of important family experiences as she does her job. She often sees little evidence that she is making a difference in the lives of vulnerable patients. She finds herself becoming apathetic to patient suffering as the day's paperwork drains her. She feels ambivalent toward patients for whom she has a dimming vision. She senses that her struggle to stay current with advancements in her specialty is posing subtle risks to patients. She is haunted by the look in her child's eyes, a look that asks, "Mom, do you care more for your patients than you do for me?" She can sound defensive. She can look disheartened.

Surgical ethics addresses the vulnerability of surgeons such as Stephanie and the many other surgeons who finish residency without such a deeply-rooted, well-grounded resolve to care for all patients – including the most difficult patients -- in a respectful, beneficial, fair, and cost-effective way. Once in practice, they too often yield – some with initial remorse – to incentives to practice surgery in a comfortable and an entrepreneurial way that actually – if subtly – discourages them from being genuinely present with patients. They too often compromise their integrity. They too often lose any initial qualms with hedging their fiduciary responsibilities to patients. They too often are easy targets. (See Appendix 1 for a language matrix that differentiates four common professional identities found on a spectrum with "I could not care less" at one end and "I could not care more" at the other end.)

Where is 'ethics' in the complexities of patient care?

'Encounter' is one of those everyday words in medicine. To encounter is to come upon another person face to face, often unexpectedly. To encounter is to meet another person suddenly, often violently. Each day is a series of encounters – turning hallway corners, crossing lanes, reaching for an object, getting in line, looking up from a table, chasing a prize, competing for a position, ... Encounters make concrete and visible the set of values, the sense of purpose, out of which we decide what ought to be done. Medical school is no exception. Residency is no exception. Academic medicine is no exception. Private practice is no exception.

Fig. 1 – an ethical anchor easily lost

'Ethics' examines how well we respect those we encounter. (Buber 1923) To respect is to see again or afresh, to look back wanting to see more clearly. The same root verb (L., *re* + *specere*) has given us such related words as speculate, inspect, spectacles, and speculum. To respect someone is to be artistic, subjective, freeing, reciprocal, gentle, engaged, holistic, attentive, patient, modest, trusting, graceful, reconciling, humanizing. But surgeons must be scientific, objective, detached. Therein lies the ethical complexity of patient encounters. A surgeon's clinical mindset can deteriorate into being rough, indifferent, curt, suspicious, selfish, alienating, dehumanizing – in short, into being disrespectful. (Fig. 1)

To be seen/treated by a surgeon as "the chest wound in Room One" or "the liver cancer in Room Two" or "the acute abdomen in Room Three" is not necessarily damaging. Excellent surgical care is evidence-based. The surgeon objectifies the patient with statistical associations or by concentrating on damaged or diseased body parts. Differential diagnoses reflect plausible cause and effect explanations. The surgeon necessarily focuses on the patient's immediate problem more than on the patient's larger story. The surgeon must be sufficiently detached to achieve *aequanimitas* or balance.

However, at some point, clinically competent patient encounters cease to be respectful patient encounters. At that threshold, only by a surgeon's being sufficiently disciplined to keep the 'aim eye' fixed on patients as individuals worthy of respect, compassion, and fairness can a surgeon avoid the indifference that degrades patient encounters into self-serving alienation . . . the indifference that leaves patients bruised, manipulated, exploited, dehumanized.

The environments for surgical education and surgical practice tend to depersonalize patient encounters. Listen to the chatter alongside rounds, note the tone in medical record entries, analyze call room conversations and physician lounge conversations, recall morbidity-mortality conferences, remember discussions about depositions or about productivity numbers, ...

For patient encounters to be truly respectful, a fourth professional language is required -- the language of respect, compassion, and fairness – that is fundamentally distinguishable from clinical/scientific language, from risk management/legal language, and from billing/economic language. Fluency in the professional language of respect, compassion, and fairness is not required to successfully complete medical school, to pass post-graduate boards, to be rewarded by practice management, to secure hospital privileges, to pass recertification examinations, to be promoted, to be elected to national positions of leadership, even to be on a hospital ethics committee. Fluency in the professional language of respect, compassion, and fairness is, however, essential for sustaining the resolve to be a humane surgeon who cares deeply about patients – especially the most difficult patients -- and who brings a resolute social conscience to the practice of surgery.

Why do well-intentioned individuals come to conflicting judgments about what should be done?

Each individual forms a personal sense as to what is of ultimate value and what is of lesser value. These core values serve as a filter through which information is interpreted before being applied to life's decisions. Certain relationships, experiences, circumstances, and objects are thus regarded to be of such importance to an individual that s/he is prepared to suffer great loss rather than to violate them.

Judgments about what ought or ought not to be done can usually be acted upon safely without much conflict. However, some situations require a collective judgment from a number of individuals with competing goals or divergent viewpoints. In such situations, a reflective approach to decision-making -- i.e., ethics -- is necessary. (Fig. 2) Ethics then has to do with the determination of what ought to be done in a given situation, all things considered.

Fig. 2 – the need for tools when facing ethically challenging cases

Some differences in judgment can be traced to variations in reasoning patterns. (See Appendix 2 for a diagram that helps clarify many of the reasoning patterns commonly present in patient care deliberations.) For instance, one person may be very logical, deductive, abstract. Another person may be more intuitive, pragmatic, relational. Other differences in judgment about what ought to be done in a given situation can be traced to variations in what is taken into consideration and the priority given to what is taken into consideration. Those conflicted about what ought to be done in a given situation may discover they are considering quite different aspects of the situation and/or they may be assigning different importance to considerations they share.

Before a thorough analysis of possible decisions can be undertaken, the participants in the decision-making process must respect each other enough to listen carefully in order to recognize and understand these differences. This approach to ethics focuses on the way we make decisions, first in reference to core values and then in reference to the interests of others affected by our decisions. It is imperative that individuals conflicted about what ought to be done cling to the 'well-intentioned' assumption about each other as long as possible and only surrender this assumption after careful/thorough examination produces overwhelming evidence to the contrary.

What are patients and their families invited to trust?

Trust is counter-intuitive . . . involves risk . . . is needed to complete most tasks . . . requires courage . . . .

'Fiduciary' in ancient Roman law denoted the transfer of a right from one person to another person with the recipient's obligation to return the right either at some future time or on the fulfillment of some condition. The fiduciary held this right as a trustee with the responsibility to exercise the right on another person's behalf. In modern surgery, 'fiduciary obligation' refers to the trust patients place in their surgeons to act in their best interests. The surgeon receives the patient's trust because the surgeon possesses the special authoritative knowledge and technical skills to which the patient seeks access. Such knowledge and skills prompt the patient to seek out the surgeon in the first place. The vulnerability acknowledged by the trusting patient creates a fiduciary obligation for the surgeon who accepts responsibility for the patient's care. (Wall and Brown 2002)

A relationship this special must be rigorously safeguarded. Accordingly, surgeons who prioritize their fiduciary obligation to patients seriously consider conflicts of interest. Surgeons are among a large and diverse work force that brings to the hospital numerous potentially conflicting priorities. (Fig. 3)

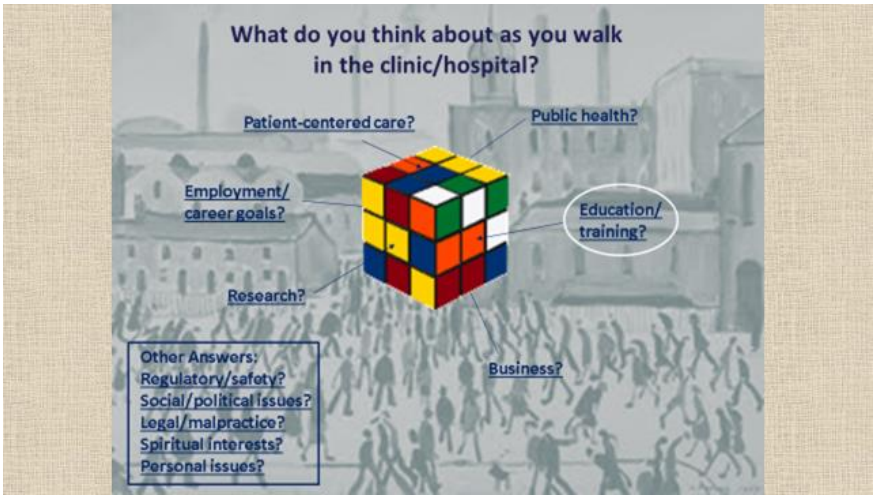

Fig. 3 – the challenge to integrate multiple potentially conflicting responsibilities

Many surgeons are engaged in clinical research and in training/education healthcare learners, both being responsibilities that use patients as means to accomplish interests other than the patients' best interests. And surgeons have to navigate the availability of commercially-driven surgical innovations that far too often result in eventual injury to surgical patients and even skew professional organization's technical bulletin guidelines. (Wall and Brown (2009)

The ethical dimensions of patient care can thus be effectively framed by asking -- "What do we invite patients and families to trust?" (Fig. 4)

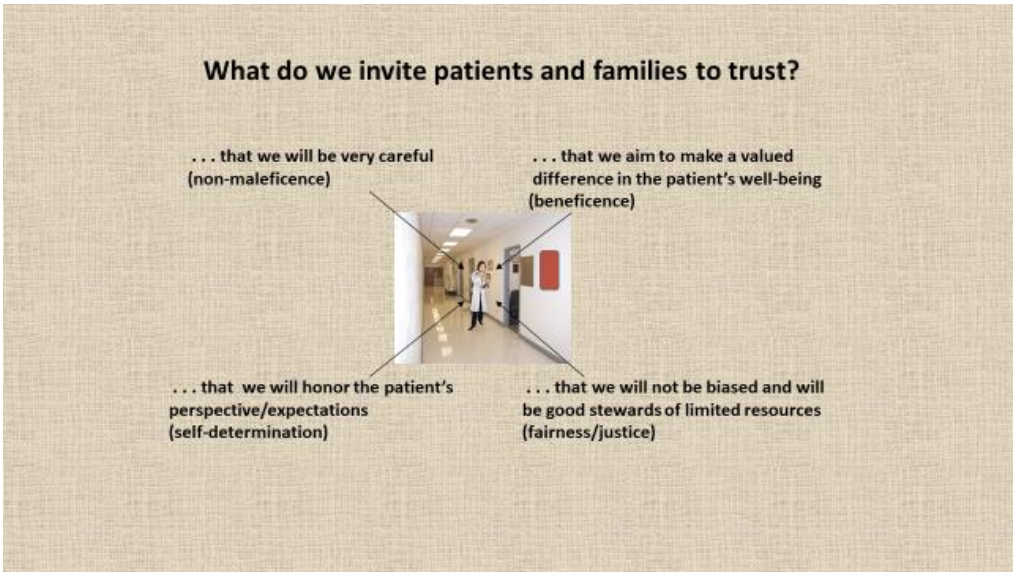

Fig. 4 – the clinical relevance of core ethical concepts

Each response to this centering question puts into clinically familiar language one of the four basic intentions that are foundational to surgical ethics -- i.e., to avoid adding to the patient's pain/suffering (non-maleficence), to make a desired difference in the patient's well-being (beneficence), to align management plans with the patient's values and goals (self-determination), and to be fair in the use of limited resources (justice). (Beauchamp and Childress 2012) When surgeons are able to follow through

on these four intentions in an integrated way, the ethical dimension of their patients' care is sound, balanced, in harmony and the surgeons experience what brought them into a surgical career. For cases in which the ethical dimension of care is shaken or broken, the centering question – "What do we invite patients and families to trust?" -- can be an effective starting point for determining which one or combination of the four intentions failed to such a degree that respect has given way to loss of confidence, suspicion, adversarial defensiveness.

The trust upon which safe and beneficial care depends is a partnership/collaboration between surgical teams and patients (with their families and friends). (Fig. 5) In order for surgeons to follow through on what they invite patients and families to trust, surgeons need their cooperation, their participation, their assistance. (Schwarze, Bradley, Brasel 2010) Thus the companion question – "What do surgeons need/expect from patients and families in order to follow through on what they invite patients and families to trust?"

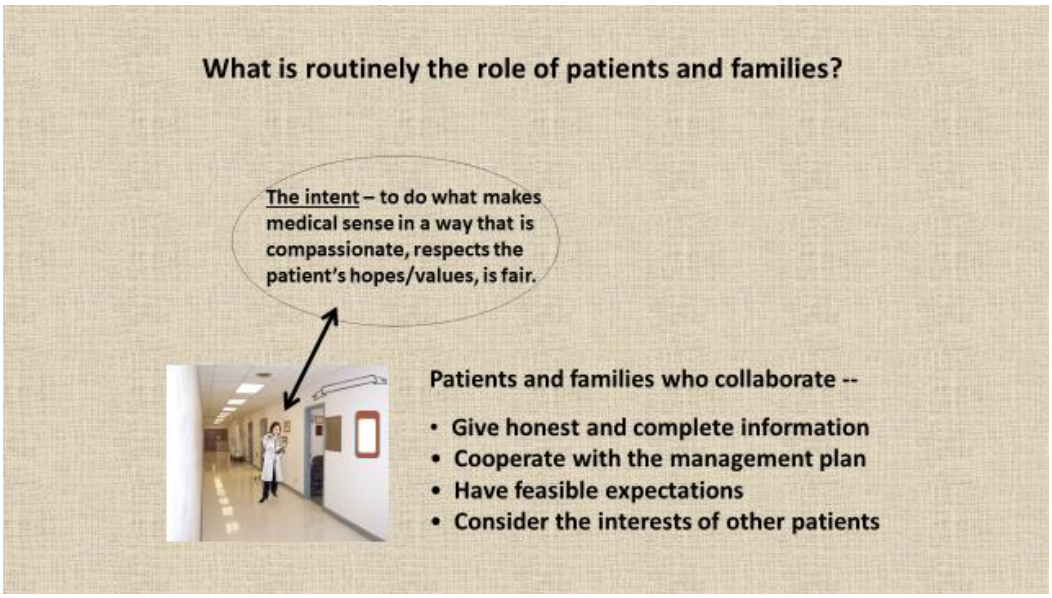

Fig. 5 – the responsibilities of patients and families

As surgeons work to avoid harm, they need patients and families to provide complete and reliable information. As surgeons seek to deliver beneficial outcomes, they need patients and families to make a determined effort to adhere to the management plan. As surgeons establish goals of care that align with patients' values and preferences, they need patients and families to realize there are limits to what can be achieved. As surgeons strive to be fair in the utilization of limited resources, they need patients and families to consider the interests of other patients and families. These clarifications highlight the accountability patients and families bear for following through on the four basic intentions that are foundational to surgical ethics.

When/why does trust break down in patient care?

One of the Cardio-Thoracic ICU attendings in the teaching hospital for a highly regarded medical school collaborated with the hospital's embedded ethics educator to identify vulnerabilities in patient care communication. The aim was to train the ICU staff to recognize early indications of breakdowns in patient communication before trust and respect had deteriorated, which was occurring in an alarming number of

cases in the unit. They eventually focused on four recurring vulnerabilities in patient care communication -- i.e., (1) the information upon which patient care decisions are made, (2) the decision-making process, (3) the goals/expectations that influence patient care decisions, and (4) perceptions of evidence-based medical reasoning. They then developed a template for examining each vulnerability in two steps -- first with a description and then with a set of assessment questions. (Fig. 6)

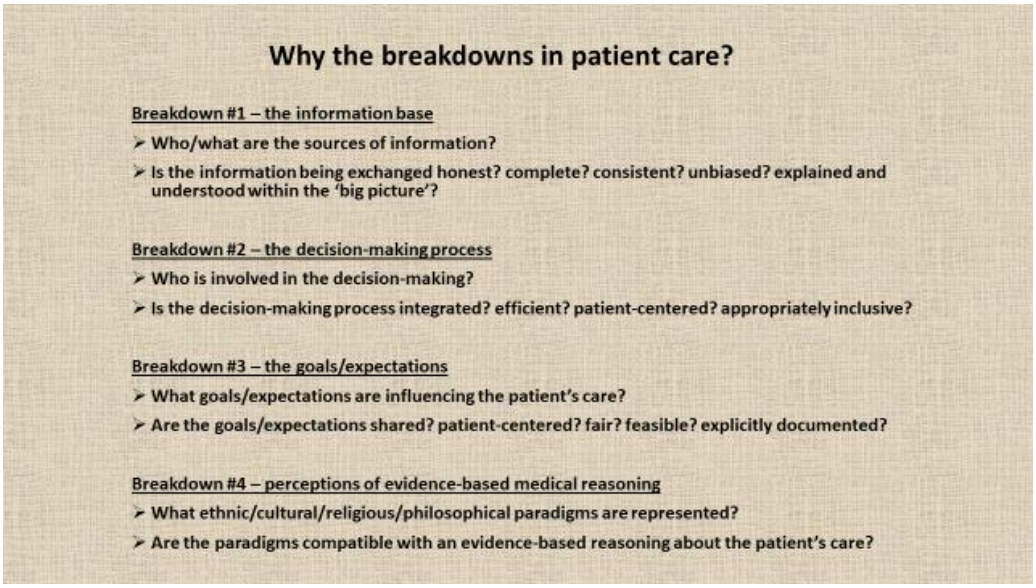

Fig. 6 – recurring vulnerabilities in patient care communication

Imagine the responsibility engineers have to ensure that bridges and buildings have structural integrity (e.g., anticipating the fatigue or fracture of materials, the initiation/growth of cracks in the materials, the limits for handling unexpected or overloading stress). Think of bridges and buildings as metaphors for the delivery of a patient's care from admission to discharge. Then reflect on the link between the integrity of the communication infrastructure upon which patient care depends and the ethical dimension of patient care.

And who is responsible for regularly assessing the communication infrastructure upon which patient care depends? The most common (and accurate) response to this question – "We all are".

When/how should patients and their families be involved in decision-making?

Consider the following encounter. An intern writes orders for a nurse to obtain several urine samples from a patient, including one for a drug screen. When the nurse asks for the urine samples, he tells the patient what tests will be conducted. When a drug screen is mentioned, the patient refuses to consent. The nurse tells the intern the patient would not consent. The intern scolds the nurse for mentioning the drug screen and tells him, "I don't care that he doesn't give consent. Go back in there and get the urine sample and send it. I will deal with the patient later." The nurse instead speaks with his supervisor.

This scenario highlights the frequent disagreements in the clinical setting over when and how to involve patients and their families in decision-making. Surgeons face four questions repeatedly in every case, with each question representing a decision about whether, when, and to what extent patients, family members, and friends should be informed and share in decision-making. These four questions for

presenting information to patients or their surrogates (Fig. 7) – i.e., Should the information be shared? or Should the information be shared as an update? or Should the information be presented with a pause to answer questions? or Should the information be shared in order to reconsider the goals of care? -- embody four phases in the century-long evolution of 'consent' in modern medicine. (Faden, Beauchamp 1986)

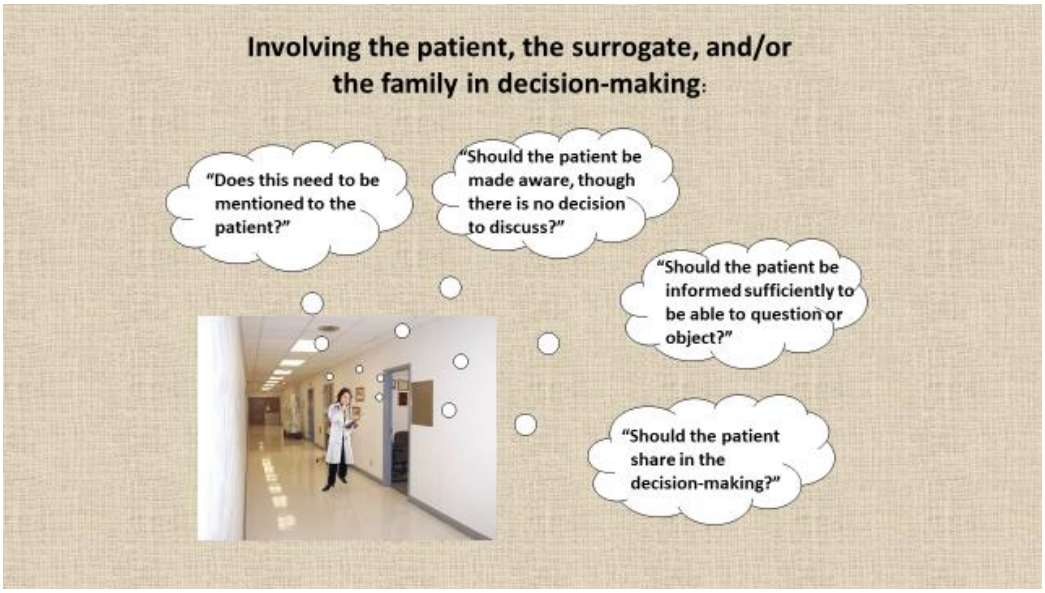

Fig. 7 – four recurring questions in communicating with patients and their surrogates

Seeing these four questions being answered repeatedly in a case after case calls attention to how few details in 'the plan for today' the surgical team reviews on rounds each day are discussed with patients or their surrogates and also calls attention to the options other than shared decision-making when information is delivered to patients or their surrogates. The pivotal consideration for ethically sound patient care centers on the surgeon's need to keep the management plan aligned with the patient's goals, values, and preferences. Any one of these four options may be ethically justified. But each of the four options necessitates separate/distinguishable ethical reasoning – e.g., What factors influence when/how a surgical team involves patients and their families? Can a surgical team explain the ethical justification for each of the four options for involving patients, family members, and friends in decision-making? This analysis also opens discussion about the significance and the limitations of decisional capacity in determining when/how to involve patients, family members, and friends.

Why is it so hard to keep sense in care at life's end?

Two residents who were near the end of their ICU rotations were asked separately – "At any given time, how many of the management plans in the ICU make no sense to you?" The question had to do with the link between the management plans and feasible outcome/discharge expectations. Both residents responded – "fifty percent".

An ethically skilled surgeon is prepared to move discussions between patients or surrogates and the surgical team toward consensus re the patient's outcome/discharge expectations. (See Appendix 3 for a comprehensive template for clarifying and documenting goals of care.) A patient's expectations may be restoration to preadmission functional status, relief from pain and suffering, survival regardless of quality of life, or survival long enough for desired closure. Quality of life outcomes that may be unacceptable to

a patient include being permanently unconscious, being permanently unable to remember or make decisions or recognize loved ones, being permanently bedridden and dependent on others for activities of daily living, being permanently dependent on hemodialysis, or being permanently dependent on artificial nutrition and/or hydration. (Fig. 8)

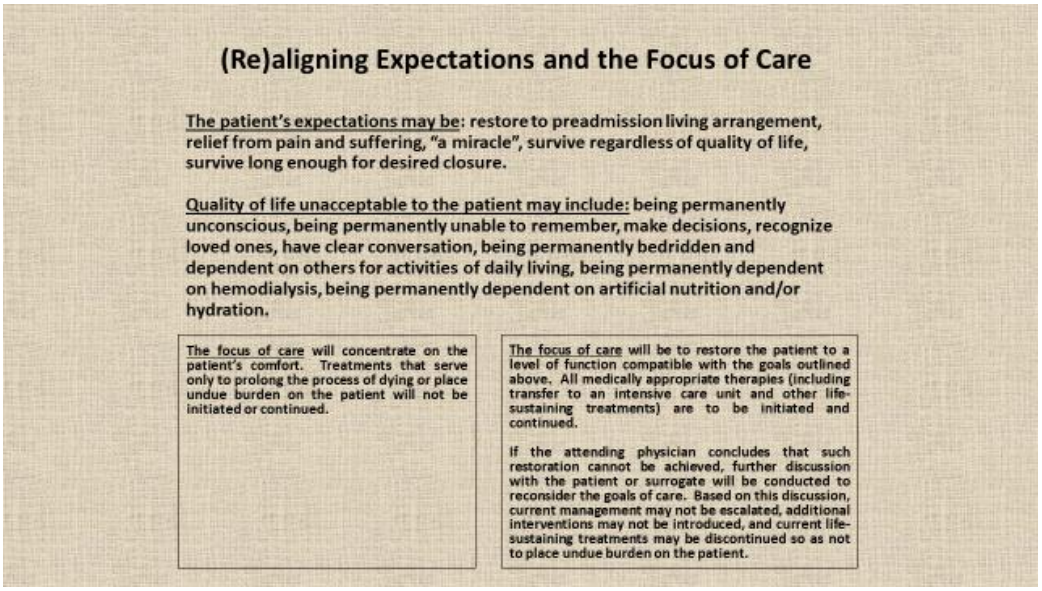

Fig. 8 – a framework for aligning patient expectations with the focus of care

The focus of care for most surgical patients is to restore the patient to a level of function compatible with the patient's expectations, with all appropriate therapies being initiated and continued. If the surgical team concludes that such restoration cannot be achieved, further discussion with the patient and family members is needed in order to reconsider the expectations for the hospitalization. Based on this discussion, current management may not be escalated, additional interventions may not be introduced, and current life-sustaining treatments may be discontinued so as not to place undue burden on the patient. In some cases, the focus of care should shift to concentration on the patient's comfort during the dying process.

Sustaining the discussion of feasible goals of care with patients and their families is an art. Here are some effective discussion starters an ethically astute surgeon may use --

- **"What makes a day 'good' for you?"** (with attention given to how 'good' is described)
- **"What are your difficult days like?"** (with attention given to how 'difficult' is described)
- **"Do your good days help you make it through your difficult days?"** (with attention to indications of how firm a 'yes' is and whether the good:difficult ratio is diminishing)
- **"Do you more often find yourself waking up in the morning hoping for a good day or hoping not to have a bad day?"** (with attention to how encouraged or discouraged the patient is)
- **"What do you want me to know as I and the surgical team consider how best to take care of you?" (**with attention oriented toward acceptable or unacceptable outcomes rather than toward management plan details)
- **"What outcomes do you want to keep fighting for?"** (with attention to how feasible the outcomes are)

- **"Are you concerned that your illness will interfere with your participation in any activities or events in the near future that are especially important to you?"** (with attention to what demands these activities or events would make on the patient, to how feasible it is for the patient to participate in these activities or events, to what condition the patient hopes to have at the time of these activities or events)
- **"Do you have any questions or worries that are hard to talk about with your family or friends?"** (with reassurances that such can be discussed with you in complete confidence)
- **"Patients sometimes tell me they find themselves thinking 'that would be worse than dying'. Have you had this thought?"** (with attention to indications re what such conditions would be)

Treatments that in the surgeon's best professional judgment will not have a reasonable chance of benefiting the patient (Fig. 9) and will serve only to prolong the dying process of or place undue burden on the patient should not be offered, initiated, or continued. (AMA 2014)

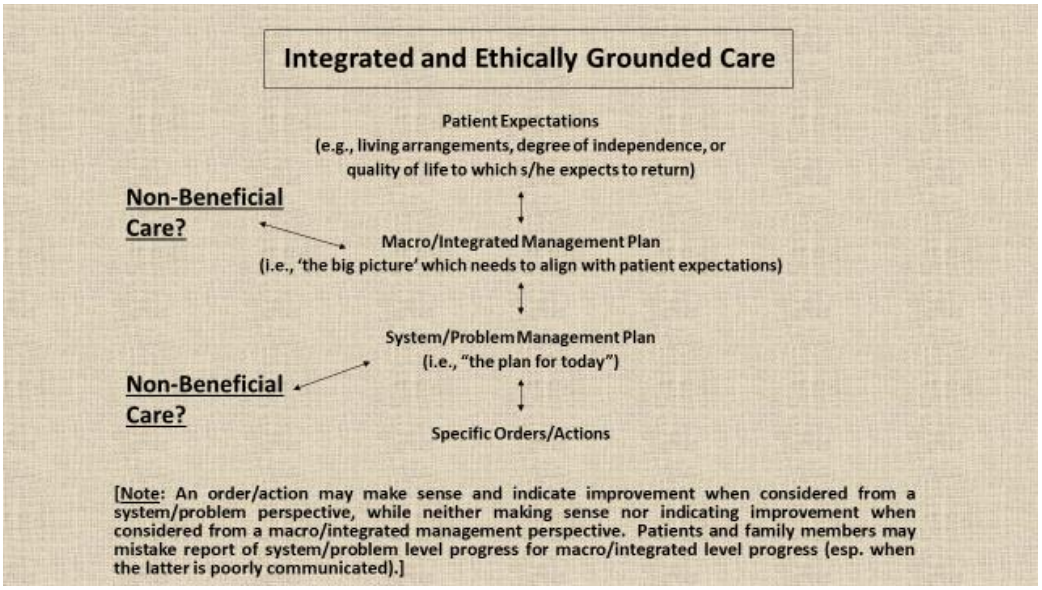

Fig. 9 – an explanation of non-beneficial (i.e., 'futile') care

Two types of non-beneficial or futile considerations create ethical dilemmas -- i.e., physiologic futility and value-based futility. A surgeon faces physiologic futility when the patient has no chance of recovery and interventions are merely prolonging the dying process. A surgeon faces value-based futility when a patient's stated goal or expectation is not achievable – e.g., a patient hopes to have meaningful conversation with loved ones but the surgeon's medical judgment is that there is no chance the ability to have meaningful conversation will be regained.

Many ethics consults are triggered when surgeons face desperate patients or surrogates who demand -- "Just do everything". An ethically skilled surgeon has learned not to be stymied by such appeals and instead sensitively reassures the patient or surrogate that everything will be done --

- that is medically reasonable, justifiable, defensible.
- that is standard of care.
- that is consistent with the patient's values, goals, expectations.
- that is within the limits of the hospital's resources and scope of service.

- that is in the patient's best interests.
- that hospital policy permits.
- that is legally permissible.

Remember – every intervention is a 'trial of treatment'.

Is concern for justice (ir)relevant at the bedside?

It is simple enough to say "I am for justice". It is much more complicated to be just. One reason -- the sacrifices and the risks associated with following through on the commitment to be just. Another reason – the reality that no single definition of what it means to be just is equally compelling and effective for all situations. (See Appendix 4 for a delineation of distinguishable descriptions of just decisions about access to and distribution of limited resources.)

Consider the experience of the leadership team for a non-profit community health center serving a patient population burdened by generations of poverty. The leadership team takes seriously the resolve in their center's mission statement to care for patients 'in a fair and gentle manner'. During a strategic planning session, the leadership team realizes they had made several decisions based on different ways to determine what is a fair use of limited resources. See if you can identify the different ways to decide what is fair that are embedded in these examples of their staffing and compensation decisions.

The community health center's seven physicians receive the same compensation. There are no productivity incentives.
Fairness is: _____

The clinical and administrative support staff members are compensated near/at their 'market' potential, with the distance from 'market' increasing across the compensation spectrum to the physicians (whose compensation is @80% of their 'market' among community health center physicians).
Fairness is: _____

End-of-the-year bonuses for non-physician employees are the same amount for all, whereas such bonuses for the physicians are calculated using an equation that takes tenure into consideration.
Fairness is: _____

The community health center is committed to delivering the same access to and quality of care to all patients regardless of a patient's ability to pay.
Fairness is: _____

The community health center gives disproportionate attention to the health care needs of and barriers faced by the most disadvantaged patients in the service area.
Fairness is: _____

The leadership team makes decisions about the utilization of the staff and capital resources based on 'public health' funding priorities.
Fairness is: _____

Is it legitimate to use different interpretations of what is fair? If so, what integrates the results into an experience that is considered to be fair? Should fairness be measured by the resulting harmony, balance, reciprocity? Are the anchors for fairness (1) treating equals equally and (2) handling inequalities with disproportionate regard for the less advantaged? If so, can complacency (or resignation) about inequalities be overcome? How do inequalities at/from birth influence attempts to be fair? Should the interests, rights, and/or liberties of a few ever be sacrificed for the interests, rights, and/or liberties of the many? How far beyond those immediately affected should consequences be tracked in assessing the fairness of a decision? How should an organization's being 'for profit' or 'not for profit' alter deliberations about a fair distribution of benefits and advantages?

Mass casualty events radically escalate the ethical challenges to be fair. Surgeons are forced to shift from the familiar individualized patient care paradigm to the less familiar public health paradigm. They are expected to be utilitarian (i.e., to deliver the greatest good for the greatest number). Resources have to be rationed. Patients have to be triaged. Potentially life-sustaining treatment may have to be withheld or withdrawn from one patient and given to another patient.

Surgeons intent on being fair invite their patients and surrogates to trust that they will not discriminate against them. Following through on this intention is especially challenging when demographic variables about which they have preferences and biases are medically significant to a patient's diagnosis and management. (Fig. 10)

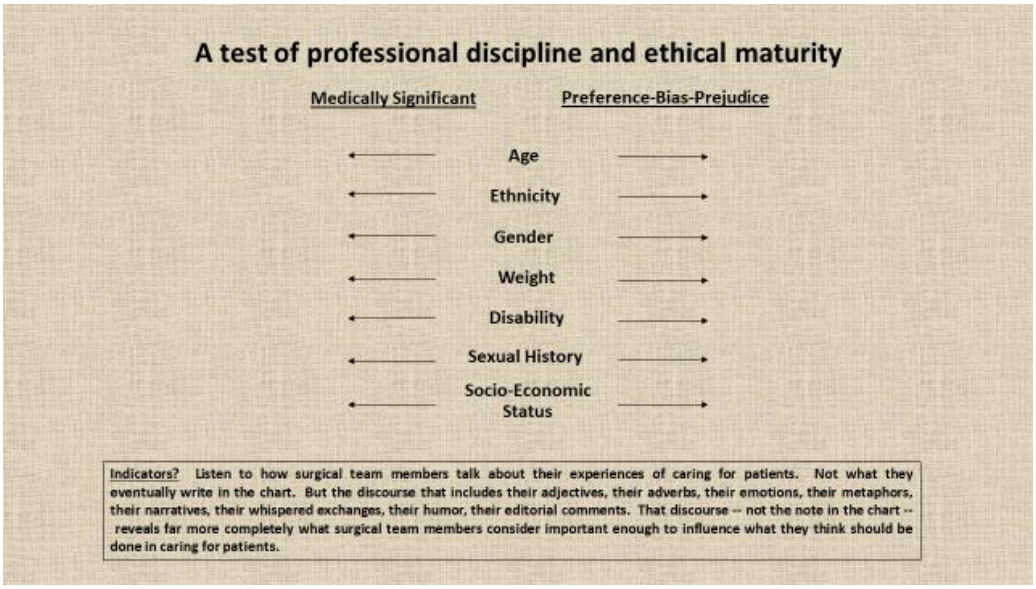

Fig. 10 – patient information that can be both medically significant and prejudicial

The responsibility to recognize and discipline one's preferences and biases when caring for patients is clearly relevant at the bedside.

Surgeons also question – often expressed with frustration and/or cynicism -- systems, protocols, and decisions for distributing limited resources (e.g., personnel, rooms, supplies, lifesaving interventions, VIP privileges, capital investments). They can feel complicit . . . but trapped/powerless. Ethically grounded surgeons look for opportunities to participate in team, department, institutional, and national efforts to assess/revise the unofficial decision-making culture and/or the official policies that raise fairness concerns about the distribution of limited resources (i.e., 'organizational ethics'). (Spencer, Mills, et al 2000)

Consider an exercise designed to clarify one's priorities re access to and distribution of limited resources. (Fig. 11) (Rawls 1999)

Fig. 11 – an ethically accountable perspective on accessing and distributing limited resources

First, visualize the range of possible life circumstances represented in the ring of photographs. Second, imagine not knowing your life circumstances (e.g., your age, ethnicity, health, work, education, financial resources, your nationality, etc.). Surgeons see firsthand how fragile and unpredictable one's life circumstances are. Third, without knowing which life circumstances will be your lot, explain how you would propose limited resources should be accessed and distributed.

"Who cares . . . really?"

Most medical students choose to pursue a surgical career confident they will be ethically model surgeons, humane with a resilient social conscience. However, they quickly feel they are being herded through year after grinding year of preparation. They are being trained, but not necessarily educated. They are under intense supervision as they expand/strengthen their knowledge base, as they become efficient in examining patients, as they learn to do procedures. From one stage to the next, they accommodate standards for identifying 'good performance' that may have little to do with valuing patients as individuals. They finish residency still feeling the effects of chronic fatigue, but anxious finally to be focusing on their own patients. Instead, for several more years -- among new colleagues and under smothering fiscal scrutiny – they struggle to find their own practice style, to get out from under enormous debt, to publish, to catch up on a long-delayed personal life. Do they receive sufficient incentives to give of themselves . . . to care deeply . . . to be truly present with their patients . . . to concentrate on the disadvantaged . . . to be reflective?

'Ethics' for these surgeons is analogous to an irrigation system delivering nourishment to plants that would otherwise wither.

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Appendix 1 -- a language matrix that differentiates four common professional identities found on a spectrum with "I could not care less" at one end and "I could not care more" at the other end.

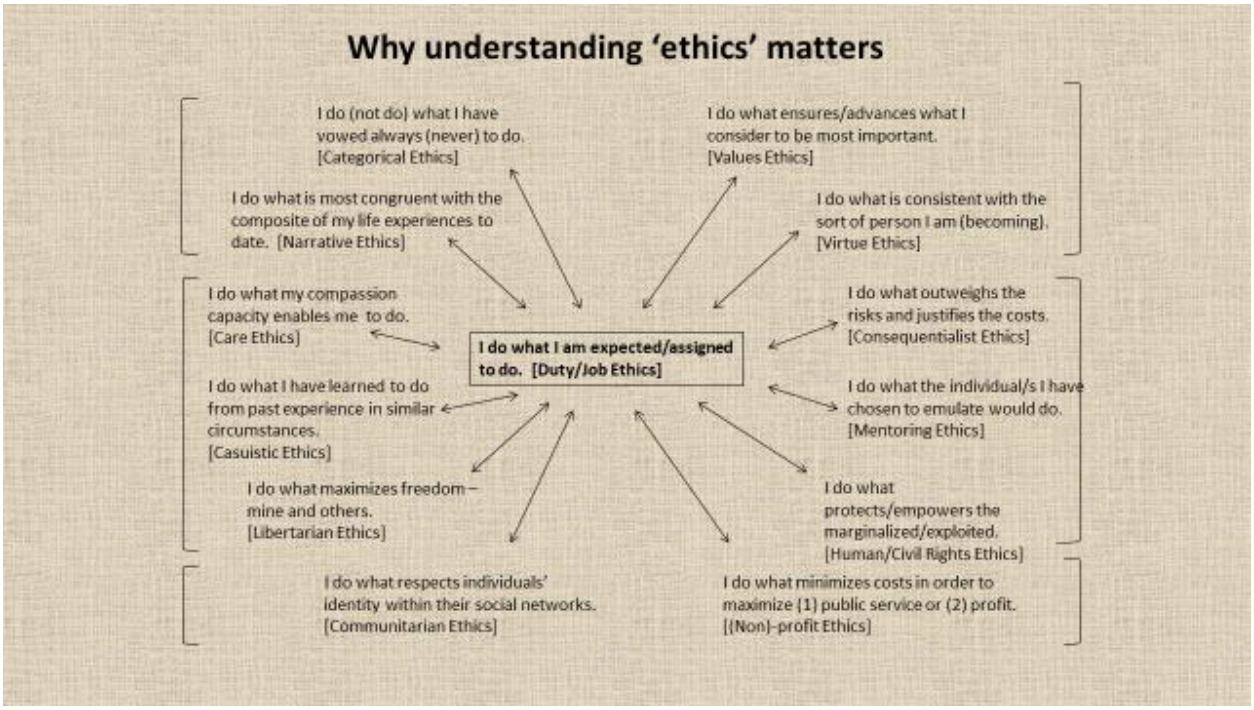
Professional Profiles That Delineate Integrity

"I could not care less" ←			→ "I could not care more"
an assault pt a victim a scam	a sale pt a consumer a business	an encounter contract with pt a profession	a meeting covenant with pt a vocation
criminal; manipulates pt; desecrates social fabric	entrepreneur; accommodates pt; capitalizes on social fabric	servant; empathetic toward pt; leavens social fabric	partner; respects pt; challenges social fabric
lifestyle is everything	lifestyle is highest priority	lifestyle is in tension with accountability to/for pts	lifestyle is integrated with accountability to/for pts
pt mix is defined by fraudulent intent	pt mix is weighted toward personal interests	pt mix is weighted toward the more vulnerable pts	pt mix is centered on the most vulnerable pts
exploits pt suffering; immune to being burned out	detached from pt suffering; avoids being burned out	burdened by pt suffering; risks being burned out	drawn into pt suffering; copes with being burned out
harmfully present pt a means only	apparently present pt primarily a means	meaningfully present pt an end and a means	fully present pt essentially an end
professional advancement sought as a cover	professional advancement sought as a marketing asset	professional advancement sought for quality of care and security	professional advancement sought as a benefit to pts
no conscience; no moral dissonance; no integrity	easy conscience; little moral dissonance; compromises professional integrity	pangs of conscience; underlying moral dissonance; wrestles with integrity	restless conscience; deep moral dissonance; risks self-righteous self-image and/or reputation

The Struggle

"I could not care less?"	"Do I care	. . . really?"	"I could not care more"
	a task pt one more demand a job	an encounter contract with pt a profession	
	mechanic; numb toward pt; tired of confrontions	servant; empathetic toward pt; leavens social fabric	
	experience with family sacrificed to care for pts	lifestyle is in tension with accountability to/for pts	
	patching rather than healing the more vulnerable pts	pt mix is weighted toward the more vulnerable pts	
	apathetic re pt suffering; overworked; drained by paperwork	burdened by pt suffering; risks being burned out	
	weakly present pt a means to an end	meaningfully present pt an end and a means	
	professional advancement slowed by being behind; subtle risks to pts	professional advancement sought for quality of care and security	
	guilty conscience; moral complacence; defensive; sounding cynical	pangs of conscience; underlying moral dissonance; wrestles with integrity	

Appendix 2 -- a diagram that helps clarify many of the reasoning patterns commonly present in patient care deliberations.



Appendix 3 -- a comprehensive template for clarifying and documenting goals of care.

Goals of Care -- Communication Template

PART A: Document Goals of Care

Based upon comprehensive discussion between the patient _____ (or surrogate) and the treating physician, the following explanation best describes the patient's current goals of care: _____
_____

EXAMPLES include but are not limited to: "return to prior living situation at previous functional status" or "return to prior living situation after physical therapy" or "remain in my home" or "be free of pain or breathlessness" or "maintain my privacy and dignity" or "be able to interact with my loved ones" or "attend my granddaughter's graduation".

NOTE: "Do everything" is NOT a goal of care. Ask the patient (or surrogate) what 'everything' is intended to achieve.

NOTE: To set realistic goals, the patient (or surrogate) needs a clear description of what to expect.

Discuss and document if the patient wants aggressive life-support measures stopped and wants treatment instead to focus on comfort and dignity if any one or combination of the following is the most likely outcome:

____ being permanently unconscious (i.e., completely unaware of surroundings with no chance of regaining consciousness)

____ being permanently unable to remember, understand, make decisions, recognize loved ones, have conversations

____ being permanently bedridden and completely dependent on the assistance of others to accomplish daily activities
(e.g., eating, bathing, dressing, moving)

____ being permanently dependent on mechanical ventilation

____ being permanently dependent on hemodialysis

____ being permanently dependent on artificial nutrition (tube feedings) and/or intravenous hydration for survival

____ death likely to occur within days to weeks and treatments are only prolonging the dying process

____ other (specify): _____

PART B: Document Focus of Care

Based upon the above understanding of the patient's goals of care:

☐ The focus of care will be to restore the patient to a level of function compatible with the goals outlined above. Specific testing and treatments will be ordered by the patient's physicians with the intent to achieve these goals.

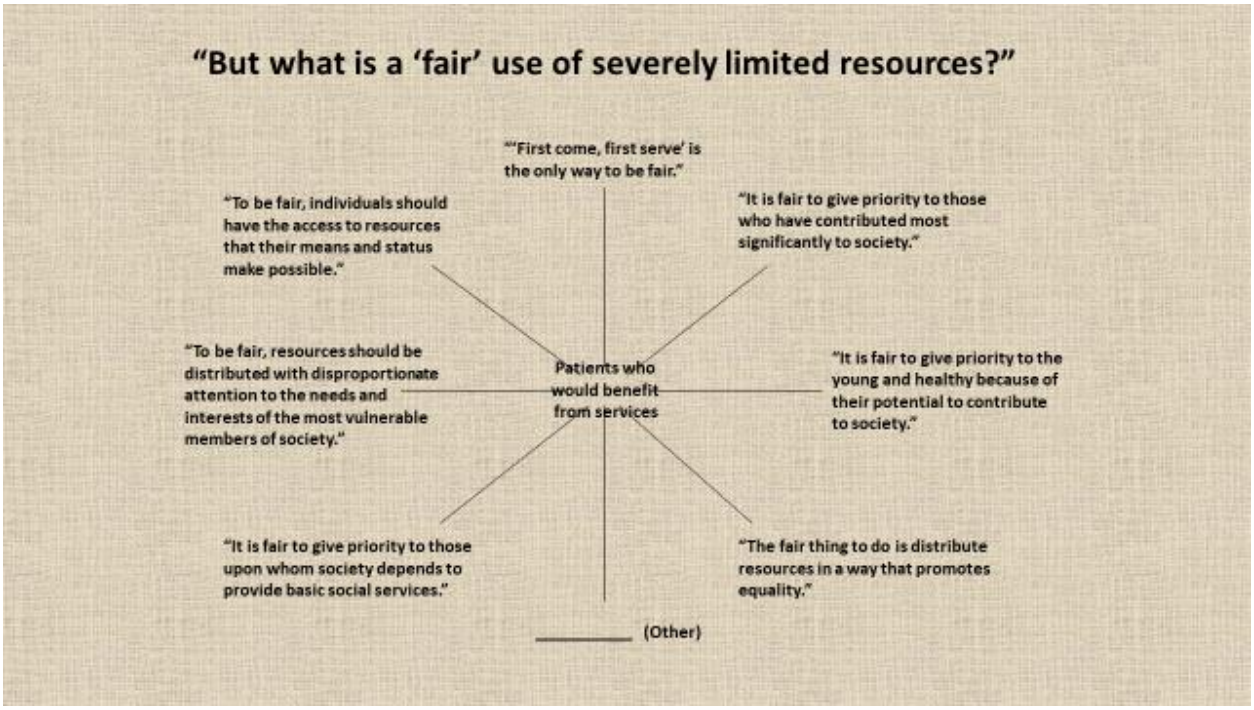
☐ The focus of care will concentrate on the patient's comfort. Treatments that serve only to prolong the process of dying or place undue burden on the patient will not be initiated or continued.

PART C: Recommend Resuscitation Status

1. Based on the current condition, prognosis and comorbidities, and on weighing likely benefits, harms and goals outlined above --
   A. The treating physician **does / does not (circle one)** recommend CPR in the event of cardiac arrest.
   B. The treating physician **does / does not (circle one)** recommend intubation in the event of impending respiratory arrest.
   C. The treating physician at this time **cannot make a definitive recommendation (circle)** regarding CPR or intubation.
2. These recommendations have been discussed with the patient (or surrogate) with reassurance that if resuscitation is not performed, treatment will be provided with the goal of comfort and dignity: **Yes / No**
3. For the patient (or surrogate) who decides to be resuscitated (i.e., Code 1) despite the treating physician's recommendation against such, the treating physician has discussed the likely immediate consequences of CPR if successful: **Yes / No**
4. **Person with whom to speak if the patient lacks decisional capacity:**

Name: _____ Relation: _____ Phone Number: _____

Appendix 4 -- a delineation of distinguishable descriptions of just decisions about access to and distribution of limited resources.



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Abstract

Surgical ethics has to do with the determination of what ought to be done, all things considered. This chapter prompts reflection on eight analytical questions – (1) What does it mean for a practicing surgeon to be 'ethical'? (2) Where is 'ethics' in the complexities of patient care? (3) Why do well-intentioned individuals come to conflicting judgments about what should be done? (4) What are patients and their families invited to trust? (5) When/why does trust break down in patient care? (6) When/how should patients and their families be involved in decision-making? (7) Why is it so hard to keep sense in care at life's end? (8) Is concern for justice (ir)relevant at the bedside?

Keywords

Ethics, Respect, Values, Trust, Fiduciary, Non-maleficence, Beneficence, Self-determination, Justice, Integrity, Informed Consent, Goals of Care

Figure legends

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Figure citation

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Suggested literature

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Remissive index

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