Surgeons discuss options when the risks of surgery may be too high

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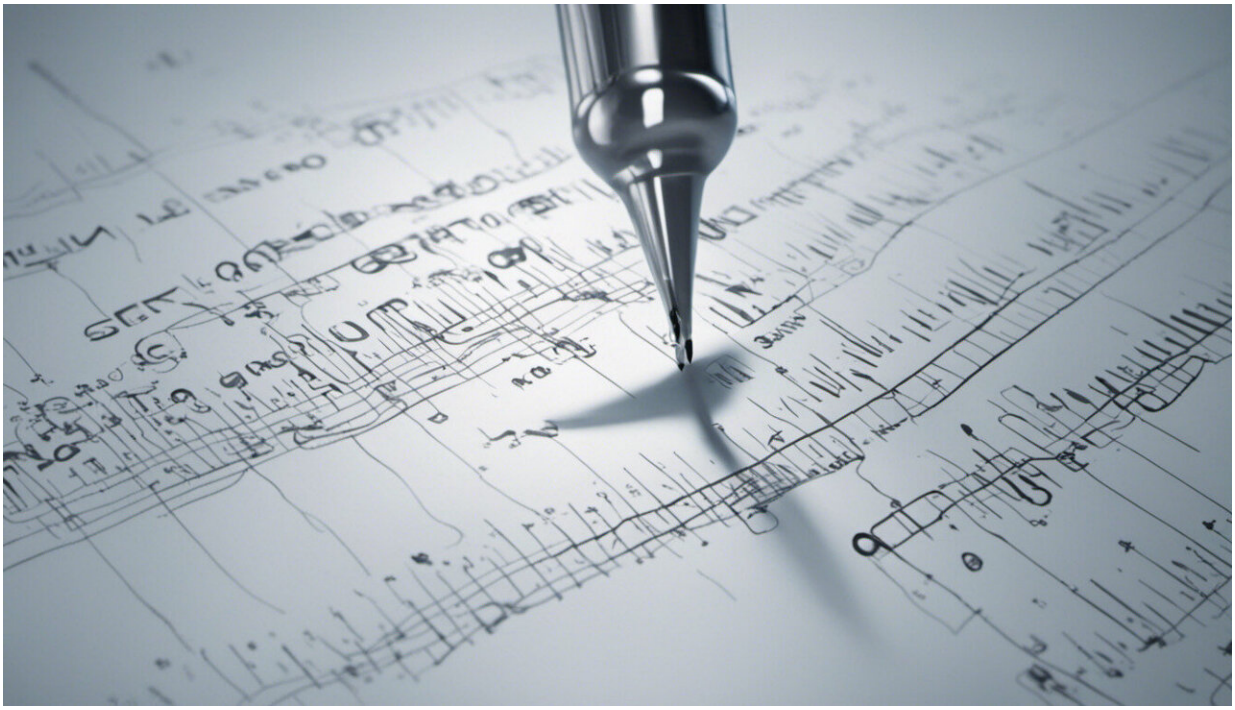

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In an essay published July 26 in the *New England Journal of Medicine*, Ira Leeds, M.D., research fellow, and David Efron, M.D., professor of surgery, both of the Johns Hopkins University School of Medicine, along with their collaborator, Lisa Lehmann, M.D., Ph.D., M.Sc., from the U.S. Department of Veterans Affairs, call for shared decision making

when a patient's risks for surgical complications may outweigh the potential benefits of an operation.

"Ethical use of health care resources, surgeon ability and experience, and patient wishes all come into play when risk factors known to predict poorer surgical outcomes are present, including obesity, smoking, diabetes and age," says Leeds. "Our essay highlights the realities for both surgeons and patients at a time of increasing focus on transparency, high value care, public reporting of clinical outcomes, and accountability, along with patient suffering in making decisions to operate or not operate."

In the essay, the authors acknowledge that surgeons now not only must consider how poor outcomes might affect the patient, but also how those outcomes may affect their personal and institutional quality rankings, which are not only increasingly available for public scrutiny but also are tied to payments by insurance companies and Medicare/Medicaid.

Inherently, Leeds says, there is an ethical concern with cherry-picking one's way to better surgical outcomes. By current quality measures, selecting the healthiest patients for operation is an easy way to improve one's outcomes. However, surgeons are ethically obligated to center their decision-making on the patient. For sick and debilitated patients, deferring surgery may be help them in the long run, but for others, deferring surgery may be ethically unbalanced, favoring the institution or society as a whole over the suffering of the individual.

Among the options and decision points that require consideration from surgeons and patients, says Efron, are when and for how long to delay surgery until risk factors can be modified, and when risk factor modification should be abandoned in the interest of alleviating a patient's surgically correctable conditions—even when risky.

In the essay, Leeds and Efron also consider the fair allocation of limited health care resources as a factor in risk assessment. For example, is it wiser to perform one high-risk surgery or two average-risk surgeries that use the same level of health care resources? A recent analysis, the authors note, showed that obesity increased the cost of a hospitalization for a person undergoing cardiac surgery by 17.2 percent on average, or $426 for each unit of body mass index. Should such cost analyses be part of the decision to operate or not operate? And importantly, who should make these assessments? The authors argue that the proximity of operating surgeons and patients to the decision's consequences requires more involvement from professional societies and other impartial third parties.

The root of conflict in the surgical selection process, Leeds and Efron argue, lies in a misalignment of goals of patients, surgeons and society. More effective shared decision making, with clear communication to patients about surgical risks and responsibilities, concrete guidelines for operating from professional societies, and consistent support from insurance companies would help align the goals.

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