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Informal contracts, shared decision-making and the covenant of care

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In this issue of *Critical Care Medicine*, Schwarze and colleagues report a national survey of surgeons that elicited opinions about perioperative life support in the framework of advance directives limiting such supports.(1)The data suggest that many surgeons expect their patients (and families, since patients often lack decisional capacity when difficult questions about intent and extent of therapy must be addressed) to "buy into" very aggressive post-operative care as part of a package deal.

Aggressive care on behalf of their patients is a normative behavior among surgeons, and therefore failure to pursue rescue of a deteriorating patient is widely regarded as a "normative error".(2)Framing a decision to withhold certain classes of care as a failure to pursue rescue seeds the discussion of "unprofessional behavior" or (worse) evidence of moral defect. Surgeons are thus socialized to use every device and drug in the armamentarium as a lifesaving tool. The major findings of the Schwarze paper are unsurprising and perhaps even comforting: patients at the edge of life need the strongest advocates if they are to survive.

Surgeons point to emerging data suggesting that failure to pursue rescue is linked to higher short-term (30 day and similar) mortality. At the 2012 of the American Surgical Association, Scarborough and colleagues reported (3) that among patients age > 64, a do-not-resuscitate ("DNR") order is associated with 1.78 fold short-term mortality versus a risk-matched set of controls undergoing emergency surgery. Given the speading use of mortality as a physician quality measure, such data can only stiffen the resolve of surgeons to do whatever is necessary to keep their patients alive—including suspension of directives that might limit a rescue attempt. Indeed, another report from this group (4) suggests that mortality-based grading ("physician profiling") might at least be influencing the decision to operate to operate in the first place.

Comes now the question of "buy-in". What is being bought, who is buying it, and what are the contractual terms? What appears to be bought (or sold) is limited agency: the patient is empowering an agent (the surgeon) to select temporary therapies in order to achieve personal health objectives, even if those therapies used long-term would be unacceptable to the patient. The wide range of times for which individual surgeons would use life-sustaining treatments suggest that specifics of the contract vary from one circumstance to the next. This

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is reasonable—after all, patients and circumstances are unique—provided that the contacting parties are clear on those specifics and mutually assent based on an understanding of the risks, benefits and alternatives. This is what we mean by shared decision-making.

One wonders whether the use of the modifier “informal” is interpreted by the responding surgeons to assume greater latitude in decision-making and broader privileges in exercise of agency. In a common patient/surrogates’ perspective, the contract grants the surgeon permission to use life-sustaining therapies in a specific circumstance to achieve a specific objective. It does not cede the right to self-determination, particularly if circumstances change. In a common surgeons’ perspective, the contract grants the surgeon permission to use life-sustaining therapies as s/he deems fit for as long as s/he deems fit. Self-determination is ceded to that most benevolent and powerful of agents, the surgeon. The contract is no longer a contract. It is a covenant in the biblical sense: “place your trust in me, and I will care for you”. (5)

Schwarze, *et al*, conclude their report highlighting the importance of preoperative negotiation to inform post-operative decision-making as a strategy towards mutual assent. To this we might add the importance of writing down the outcome of the negotiation so that all parties know what authorities have been assigned, to whom and for how long. Is it a granting of agency or a ceding of autonomy? Surgeons and their patients need to know.

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