Ethical Considerations

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Jun Xu and Daniel E. Hall

10.1 Case

An 83-year-old man was transferred to our tertiary care center after reporting to an urgent care center with new onset of back and abdominal pain. A noncontrast CT scan there confirmed a 10-cm juxtarenal abdominal aortic aneurysm with some stranding in the retroperitoneum, indicating a contained rupture. He has significant cardiovascular comorbidities including coronary artery disease that required a 3-vessel coronary artery bypass at age 50. On presentation, the patient is tachycardiac but otherwise stable. He appears to be in mild distress but is otherwise alert and oriented.

10.2 Introduction

This and other situations like it are all too common in vascular surgery. And they are difficult. The right and good course of action is not always clear on the face of facts because what might be good for one patient, might not be good for another patient in similar clinical circumstances. Moreover, such decision making is often caught up in a confusing interface of capacity, consent, and often misguided expectations in and around the end of life. How is a surgeon to navigate this terrain?

Clinical decisions are made through partnerships between physicians and patients. Whether we recognize it or not, each clinical decision includes an

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J. Xu
Division of Vascular Surgery, University of Pittsburgh Medical Center, Pittsburgh, PA, USA

D.E. Hall (✉)
Division of General Surgery, University of Pittsburgh, Pittsburgh, PA, USA
e-mail: hallde@upmc.edu

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ethical choice just to the extent that each decision aims at serving the patient's "good." What is ultimately the right thing to do therefore depends on how each patient and physician understand that "good." The right and good action must not only be informed by the scientific evidence but also take into account the patient's values and the surgeon's own clinical judgment. The following pages lay a foundation for a systemic approach to just this kind of ethically sensitive medical decision making.

10.3 Urgency

Depending on the urgency of the situation, the surgeon and patient may or may not be able to engage each other in every aspect of an ideal decision-making process. In fact, in absolute emergencies, surgeons are empowered to make decisions unilaterally (e.g., the trauma bay). This extraordinary power and responsibility is justified because it is reasonable to assume that most, though not all, patients would prefer to live than to die [1]. Preserving life in these circumstances may also permit patients to make their own choices after the urgency resolves. However, surgeons must exercise this power with extreme care, especially in circumstances where there may be doubt that preserving life is preferable to immanent death. Indeed, a growing literature demonstrates that elderly patients frequently fear invasive treatments and debilitation more than death. For example, one study of seriously ill patients ≥60 years of age found that 99% would agree to a low-burden treatment that was likely to restore current health, but if the treatment was associated with a significant chance of functional or cognitive impairment, 74–94% of patients reported that they would forgo the treatment, even if it meant they would not live as long [2]. The repair of ruptured aortic aneurysms is associated with just these kinds of impairments. Further, the SUPPORT trial demonstrated that many critically ill patients received more invasive treatment than they preferred (e.g., such as surgery) [3], and other research shows that patients often receive treatment that is inconsistent with their values and preferences [4, 5].

The patient in our vignette is hemodynamically stable, but there is a rupture and a decision must be made regarding the next steps. Extensive deliberation is a luxury that neither party can afford. However, there is probably more time to engage in shared decision making (SDM) than is often practiced. For example, the patient could probably wait for an hour or two and weigh his options or wait for the arrival of a trusted family member. But many patients like this will be ready to decide in minutes. Part of the surgeon's responsibility is to discern the time available to make a decision without significant impact on the range of options. If we wait too long, the optimal surgical treatment may no longer be possible. If we act too soon, we may not accurately discern the course of action most suited to the patient's values and goals. Finding the balance between these extremes requires the wisdom of experience.

10.4 Capacity

When time permits, ethical and legal standards require surgeons to involve patients in the decision-making process. To do so, patients need to have decision-making capacity. Capacity is a relatively fluid concept that describes a person's ability to make an informed decision.

In general, four elements are needed to determine capacity, and these are sometimes coupled with the criteria of informed consent: (1) patients must be able to express a choice, (2) understand the surrounding circumstances, (3) appreciate the nature and significance of the decision as well as be able to (4) reason from the understood and appreciated facts to a coherent decision [6–8]. The ability to express a choice is perhaps the least abstract of these criteria: if the patient expresses an opinion, he/she essentially has this capacity. Of course, it is possible to imagine scenarios where patients' understanding and appreciation and reasoning are all intact, yet have no way to express or communicate their informed, reasoned decision, but these instances are rare. Once the patient has expressed a preference for his/her care, the surgeon should then assess the patient's ability to understand the risks and benefits of the clinical options. For capacity to be clearly evident, the patient must go beyond mere comprehension in order to demonstrate an appreciation of what those risks and benefits mean to him/her. That is, patients must recognize that their own lives, values, and futures are at stake, and that the 10% chance of graft infection could *actually happen to them*. Finally, after understanding and appreciating the relevant facts, patients must take those facts and reason with them to choose a course of action that is recognizably coherent. When making a determination about capacity, the focus is not so much on the merits of the decision, but on the integrity of the process by which the decision was reached. Even though the surgeon may disagree with the Jehovah's Witness who chooses to eschew transfusion, that surgeon can recognize that the decision is coherent within the assumptions of the patient's worldview and the relevant facts of the case.

Finally, it is important to recognize that decision-making capacity is always contextual to the decision in question. Patients may be perfectly capacitated to choose clothing or menu items, but incapacitated to choose between open versus endovascular approaches to aortic rupture. Furthermore, during the course of medical treatment, capacity may wax and wane throughout the day or the week with changing orientation and episodic delirium. High-quality shared decision making demands that vascular surgeons attend carefully to patients' capacity to share in the decision making, aware that this capacity may change from patient to patient, and from hour to hour with the same patients.

An example of patient with impaired capacity might look like the following: Mr. Jones understands that his aorta is ruptured and that surgery entails risks of, among other things, renal failure, graft infection, and profound deconditioning requiring long-term rehabilitation in a nursing home, but in justifying his preference for surgery, he repeatedly states he "always beats the odds" and that "these things just won't happen to me." Furthermore, he states his belief that surgery will rapidly restore him to independent living at home. There may be compelling and justifiable reasons to proceed to the operating room, but at this juncture, Mr. Jones does not demonstrate capacity to make that decision by himself, and the surgeon would be wise to contact Mr. Jones' surrogate decision-maker.

10.5 Surrogate Decision-Making

If a patient demonstrates decision-making capacity, then the medical decisions rest with the patient, in consultation with the surgeon. When patients are incapacitated, medical decision falls into the hands of a surrogate. Some patients will formally document their choice for a healthcare power of attorney to serve this purpose. If none is designated, then there are state statutes that rank the applicable hierarchy of surrogates (e.g., spouse, adult child, parent, sibling, family member, and friend). If the statutorily defined surrogate is not available, pragmatic decisions can be made with the patient's family, domestic partner, or close friend. Surgeons should be careful to understand the precise hierarchy established by the state in which they practice. They should also recognize that not all powers of attorney are authorized to make healthcare decisions (e.g., financial powers of attorney). Before accepting the assertion of decision-making authority, careful questioning should clarify that the surrogate is actually the *healthcare* power of attorney.

Living wills and other so-called "advance directives" are another resource for surrogate decision-making, although they are often unavailable during medical emergencies. Generally, a living will is a document that conveys a patient's preferences for healthcare decisions in the event that the patient is incapacitated. It typically includes a list of permitted and/or forbidden technologies and treatments. Although technically precise, the challenge with living wills is interpreting the clinical context in which they should be enforced: Does Mr. Jones' instructions against dialysis apply to the current context of acute renal failure 4 days after cross clamping his aorta at the diaphragm? Living wills generally address only the broad context of end-of-life decisions. They cannot anticipate all the serious medical circumstances the person may face in the future where their preferences for life-sustaining technologies might change.

Further complicating the interpretation of advance directives is the fact that patient preferences can change with the passage of time. Living wills are often created long before serious decisions actually need to be made, so highly specific directions may not have been intended for new and unforeseen circumstances. And even if the living will was recently developed, the psychological phenomenon of "affective forecasting" demonstrates that human beings have only limited abilities to accurately predict future preferences before they actually experience the events that would make those preferences relevant [9]. The preferences recorded in living wills can and should inform clinical decisions, and it is often better to know those preferences than not, but living wills cannot replace good clinical judgment because the details of particular clinical contexts can raise legitimate doubts about the applicability of the living will. Therefore, it is our experience that living wills are most useful when interpreted not in isolation, but in cooperation with a responsible human surrogate who can help clinicians discern if and how the living will should apply.

Surrogates are asked to put their own interests aside and make decisions on behalf of the patient, based on their knowledge of the patient's values, in order to approximate the decision the patient would have made themselves. This emphasis is important to guard against conflicts of interest that lead surrogates to make decisions for personal gain rather than for the patient's interests. However, it is a challenging task to step into somebody else's shoes, and even with a responsible surrogate, substantial obstacles complicate the decision-making process. For example, although surrogates can be trained to predict the healthcare preferences of their loved ones with some accuracy [10], when left to themselves they do so only slightly better than a coin toss [11, 12]. And physicians do even worse than surrogates in predicting their patients' treatment preferences [13]. Thus, although patient preference is always a good place to begin, it is often impossible to know with certainty what patients themselves would choose, and thus surrogates (and physicians) frequently make decisions on their understanding of the patient's best interests. Due diligence is required so that surrogates and physicians do not simply do what is right in their own eyes, and consultation with the patient's primary care physician can often clarify this process. However, in settings such as ours, vascular surgeons are often left to gather the best available information about the patient's values and then discern the course best aligned with their limited understanding of those values.

10.6 Informed Consent

Once the parties sharing in the decision making are determined, the process of informed consent is engaged with either the patient or the surrogate. Informed consent is a relatively new concept for medicine, rising to prominence only in the 1970s. In previous generations, it was generally accepted that the physician's primary task was to inspire the confidence and trust to work in the best interest of the patient. Any disclosure of possible difficulties might erode that trust [14]. However, beginning in the early twentieth century, a series of lawsuits eventually established patients' rights to self-determination regarding medical treatments. One of the earliest precedents in *simple* consent was established in 1914 when a surgeon removed a tumor from the abdomen of a patient who had consented to only a diagnostic procedure. The judge ruled that the physician was liable for battery because he violated an "individual's fundamental right to decide what is being done with his or her body." [15] By the mid-twentieth century, increasing pressure emerged to *inform* patients about the proposed treatment before obtaining their consent. This pressure was partially a reaction against the perceived paternalism of physicians. Surgeons were first required to disclose what other surgeons typically disclosed about the procedure (e.g., the reasonable physician standard). In many jurisdictions, the requirement later shifted to disclosing what the typical patient would want to know (e.g., the reasonable patient standard), including risks, benefits and alternatives of the proposed treatment as well as the risks of not acting or postponing treatment [16].

Regardless of the applicable legal standard, the precise amount of information that needs to be disclosed remains controversial. Some studies suggest [17, 18] (and some courts demand [16]) that physicians disclose risks as rare as 1:14,000.

However, not only would this be impractical, but other studies consistently demonstrate that patients do not remember much of what is disclosed during informed consent [19–22], and that they often overestimate their comprehension [23–25]. Furthermore, there is strong evidence to suggest that patients have varying preferences for information quantity [17, 18, 26–30] and decision-making style [31] (e.g., active vs. deferential). Finally, there is other evidence to suggest that patients' do not always use the information to inform a deliberative decision-making process, opting instead for intuition, instinct [32–35], or a "leap of faith" into the surgeon's care [36, 37]. These and other similar data demonstrate that the ethical and legal ideal of informed consent is rarely, if ever, achieved in practice.

Although the ideal informed consent process is rarely achieved, many surgeons do engage informed consent with substantial effort [38], and those efforts clearly impact patient comprehension and decision making [39–41]. Some surgeons may fear that the legal standards for consent are unattainably high, but it is important to note that deficiencies of informed consent rarely constitute the primary focus of litigation, more often appearing as an adjunct to litigation resulting from bad outcomes. Indeed, legal advice on informed consent is pragmatic, recommending candid communication tailored to each patient's needs rather than to abstract and overly precise risk thresholds [42]. Well-documented, good-faith efforts to involve patients and their families in surgical decision making can satisfy relevant requirements without undue burden to busy clinicians [43].

10.7 Shared Decision Making (SDM)

Although informed consent remains a legal requirement, the concept of "shared decision making" is increasingly influential in both legal and ethical writing [44–46]. Consensus regarding the conceptual model for SDM is still emerging [47], though many elements are shared across the various existing models. For example, Godolfin describes eight elements of shared decision making that describes what the best surgeons have always sought to do (Table 10.1) [48]. The goal is neither to provide a mini-medical education nor to "Mirandize" patients against all possible perioperative risks in an attempt to divest the surgeon from moral responsibility for the decision. Rather, an open discussion describing facts relevant to the decision should be shared so that the patient can participate in the decision-making process. Furthermore, the physician should not shy away from a recommendation, even if it is to do nothing; this also necessitates that the rationale for the recommendation be shared with the patient. If the surgeon thinks that the patient has a significant chance of not surviving the surgery, then the conversation should discuss those risks candidly. The conversation can be framed in a way such that the patient's values are acknowledged in the context of realistic expectations. Such a discussion should empower the patient to take ownership of and share in the responsibility of that decision.

Robust shared decision making is often best achieved in the context of an ongoing relationship of mutual trust and respect. Such a relationship might exist even in the emergent context of our vignette if the surgeon had been managing the patient's

Table 10.1 Eight elements of shared decision making [48]

1. Develop a partnership with the patient.
2. Establish or review the patient's preferences for information.
3. Establish or review the patient's preferences for his or her role in decision-making and the existence and nature of any uncertainty about the course of action to take.
4. Ascertain and respond to the patient's ideas, concerns, and expectations.
5. Identify choices and evaluate the evidence in relation to the individual patient.
6. Present evidence, taking into account points 2 and 3, above, framing effects, and so on; help the patient to reflect upon and assess the impact of alternative decisions with regard to his or her values and lifestyles.
7. Make or negotiate a decision in partnership and resolve conflicts.
8. Agree upon an action plan and complete arrangements for follow up.

peripheral vascular disease while following the seemingly stable aneurysm over time. However, the absence of a long-term relationship does not preclude the possibility of building trust and respect quickly, and engaging an urgent, yet thorough, decision-making process. One technique that has been helpful to improve communication and patient comprehension of the shared decision is to systematically ask patients to "repeat back" their understanding of their prognosis, and what they have understood about the proposed surgical treatment [40, 49–52].

Both the quality and pace of the shared decision will improve when surgeons have a clear view of how decisions are actually shared, including the distinct roles played by both the surgeon and the patient. Surgeons bring to the decision their unique experience treating multiple patients with similar disease. This experience, accumulated through years of practice, endows the surgeon with what Aristotle called "practical wisdom" (Greek: *phronesis*), defined as the capacity to choose the best from among multiple imperfect options [53]. In the same way that a mason, by virtue of his/her long experience mixing mortar and stacking bricks, is uniquely suited to choose the best way to build a wall that stands straight and bears weight, so also, a surgeon, by virtue of his/her long experience caring for vascular disease, is uniquely suited to choose among the available surgical options.

However, practical wisdom does not exist in a vacuum: it can only be exercised toward a specific "goal" (Greek: *telos* from which English gets teleological). The wisdom of the mason's choice is confirmed by the wall standing straight and bearing weight. The wisdom of the surgeon's choice depends on how well it achieves the patient's goals, and thus it is impossible for surgeons to exercise their practical wisdom without first understanding what their patients want to achieve. This requires detailed and rich conversations with the patient: The patient shares his goals, and the surgeon shares his/her practical wisdom. Because they lack experience treating surgical disease, patients cannot have a surgeon's practical wisdom, and forcing them to choose between the multiple imperfect options is a form of moral abandonment against which many patients resist (e.g., "Why are you asking me to decide, doc? You're the one who went to medical school"). On the other hand, presuming to choose a plan of treatment without a rich understanding of the patient's goals is the kind of paternalistic tyranny against which the doctrine of informed consent was erected. Shared decision making requires that surgeons shoulder the moral responsibility of exercising their unique practical wisdom, but doing so also requires clarifying the patient's goals of care in ways that can frequently elude surgeons [54].

10.8 Establishing Goals of Care

For many surgeons, the goals of therapy are most often assumed: restore functional anatomy with minimal morbidity. The surgical literature focuses on survival, complication rates, and quality adjusted life years as the common goals of the profession. Those goals can and do influence surgeons' work. Indeed, they are some of the most important goals that patients hope surgeons can help them achieve. However, the exercise of practical wisdom requires richer, thicker, and deeper discussions that explore what it means for patients to not only live but also flourish. Patients want to keep living, but does flourishing include short (or long) term sustenance on ventilators or dialysis machines? Does flourishing require independence in the patients' own home, or are they open to long-term (or permanent) living in a nursing home? Practical wisdom requires asking patients what makes life worth living. It requires exploring fears, hopes, and dreams, and among the old and seriously ill, it requires asking what patients most want to accomplish with the limited life that remains. In our vignette, if the patient's greatest fear is an extended stay, unconscious in the ICU, the wise choice may direct the patient to hospice rather than the ICU. Likewise, for a frail patient who wants nothing more than to attend his granddaughter's wedding the next day, the wise choice might be to defer his carotid endarterectomy even as he is experiencing crescendo transient ischemic attacks.

Establishing the goals of care is often difficult and uncomfortable, especially among old and frail patients who are approaching the end of their lives. Surgeons have rarely received dedicated training in how to lead these discussions with skill and grace. And in practice environments that do not reward the time and effort spent on setting goals, it is not surprising that the goals of surgical care are frequently underdeveloped. However, the difficulty of establishing goals does not diminish its critical importance.

The skills for clarifying goals can be taught, either through self-directed learning or through interactive simulation [55, 56]. However, given the realities of modern surgical practice, busy surgeons may need help elucidating their patient's hopes, dreams, and goals for surgery. In such circumstances, palliative care consultation may be helpful not only to clarify goals but to ensure that appropriate advance directives are in place, including an identified surrogate. Indeed, there is emerging evidence that early palliative care consultation can improve both quality and quantity of life among those with advanced cancers [57, 58]. In fact, one study has demonstrated significantly increased survival among surgical patients when palliative care consultation is ordered by the surgeon before the operation [59]. All of this suggests that palliative care consultation may be a critical part of the preoperative workup and optimization of high-risk patients, especially when patients are elderly or frail. (See Chap. 2 for further discussion of preoperative workup and optimization of older patients with vascular disease.)

10.9 Intensity of Postoperative Care and Time-Limited Trials

Recovery from a ruptured aortic aneurysm is intense and fraught with complications. Studies repeatedly demonstrate that the risk of complication increases dramatically among the frail elderly [60–64]. As such, older patients considering major vascular surgery need to understand that postoperative complications are not only possible but likely and expected. Therefore, successful recovery from major vascular surgery depends largely on the patient's and surgeon's mutual commitment to treat reversible complications as they arise. Indeed, vascular surgeon Gretchen Schwarze has described how most high-risk surgeons consider the consent process to entail "buy-in" to the index operation *as well as any reasonable rescue therapy* that may be needed in the immediate postoperative period [65–67]. Unfortunately, the data also show that only a minority of surgeons negotiate this buy-in explicitly, and even when they do, patients often fail to understand what the surgeon intends [66]. This failure to communicate can lead to confusion and conflict in the postoperative period, especially when complications render patients temporarily incapacitated.

One helpful way to manage the intensity and duration of postoperative care involves the *explicit negotiation* and *documentation* of a time-limited trial [68]. Time-limited trials are agreements between patients and clinicians to use specific medical therapies over a specific time during which the patient's prognosis can clarify. If the patient is improving, aggressive support continues. If the patient's recovery stalls or deteriorates, support can be withdrawn.

Negotiating time-limited trials requires frank discussions about the expected range of rescue therapies that might be required, including: (1) protracted stays in the intensive care unit (ICU), (2) the need for extended mechanical ventilation and tracheostomy, (3) the chance of acute or chronic renal failure requiring temporary or permanent dialysis, (4) the likelihood of protracted rehabilitation in a nursing facility, (5) the possibility of short-term gastrostomy for nutrition, and (6) the possibility that the best case scenario might include long-term disability and dependence. In much the same way that patients delegate the choice of suture or scissor to surgeons acting as fiduciary agents [69], patients can delegate the choice of rescue therapies to the surgeon and ICU team *for a limited time* to exercise their best practical wisdom in achieving realistic and explicitly described goals for recovery. After the limited time, if the prognosis remains unclear, new decisions can be made to extend, limit, or withdraw support.

Patient's (or their surrogates) are always free to refuse specific therapies as they become necessary, but the principles of distributive justice can impose limited obligations on patients to do what is necessary for an operation to succeed after they have chosen to consume the substantial and limited resources required to complete the index operation. Indeed, part of the surgeon's responsibility is to encourage patients to endure sometimes burdensome therapy that is occasionally necessary to achieve the patient's overarching goals. This discernment requires practical wisdom, and it often requires time for the patient's particular prognosis to emerge.

Ideally, agreements about time-limited trials for postoperative therapy would be reached before the index operation and shared with not only the hospital team but the patient's family and identified surrogate. Early consultation with palliative care specialists can again facilitate this process. Careful planning before the operation can preempt much of the confusion and conflict that attends those patients who experience complication or protracted recovery. Even in instances where a shared decision-making process was inadequately engaged prior to the index operation, instituting a time-limited trial is still useful in negotiating the intensity of treatment postoperatively in circumstances where unanticipated complications put the near and long-term prognosis in doubt. In these cases, negotiating a time-limited trial can afford time for a clearer prognosis to emerge.

10.10 Withdrawal of Support

Not all surgeries go according to plan, and when surgeons operate on elderly patients, some of them will die. Although such deaths are always sobering, they are not necessarily failures because death can be a calculated risk to achieve concrete and mutually agreed benefits. Sometimes the risks are so high that there is no reasonable chance of benefit, and surgeons have always sought to identify these patients preoperatively, steering them to more appropriate, nonoperative management. Unfortunately, traditional strategies for risk stratification systematically underestimate mortality and morbidity in high-risk populations [61, 70–73] and psychological dynamics tend toward a "Lake Wobegon effect" [74, 75] where every patient (and surgeon) is above average. However, an increasing array of powerful risk-prediction models are now available to assist patients and surgeons with patient- and procedure-specific risk profiles that can inform both decisions for or against operative management, as well as strategies for perioperative optimization when surgery is indicated [76, 77].

Although preoperative risk stratification may decrease the frequency of perioperative death among older patients, it will not eliminate it. In these circumstances, withdrawal of care may be indicated. The technical aspects of withdrawal are straight forward and can be managed by the surgeon or ICU team without difficulty, but the decision to act can be challenging. Surgeons develop emotional commitments to patients that sometimes delay recognizing that our best efforts will not help the patient to flourish. Attending to these emotions demands disciplined self-reflection that leads to realistic self-knowledge.

Even when the surgeon recognizes that the time has come to withdraw, it is often difficult to convey the reasons for this decision to the patient, their family, and other members of the healthcare team. Again, skills for communicating bad news can be learned [55, 56], and palliative care specialists can be helpful in this regard. But in the end, the surgeon cannot delegate this critical task because prudent discernment regarding withdrawal depends on the practical wisdom garnered specifically from the experience of practicing vascular surgery. Shouldering this responsibility is one of the greatest privileges and prerogatives of surgical practice, and when done in collaboration with the patient, family, and other medical colleagues, it can also be profoundly rewarding.

10.11 Conclusions

Returning to our case, after evaluating our patient with a ruptured aortic aneurysm, we explained that his condition was likely lethal without an operation, but that the operation itself might very well cause more problems than it solves due to his high risk for postoperative complications. We spent some time asking about the patient's hopes and fears in the twilight of his life.

His initial inclination was to choose surgical therapy, but he first wanted to discuss the matter with his daughter who lived nearby and was currently on her way to the hospital. We waited close to an hour for them to arrive while we completed the ACS NSQIP risk calculator for the proposed procedure in this patient.

By the time the family had arrived, our palliative care colleague had joined us by the patient's bedside where we spent nearly 20 min clarifying the patient's goals, and signing papers making the daughter his official healthcare power of attorney. He had reconciled himself to growing dependence on nursing care, but still found delight in the daily paper, his extensive collection of swing-era jazz, and regular visits from his daughter and grandchildren. His greatest fears were permanent cognitive impairment and dependence on mechanical ventilation. In hopes of restoring him to Duke Ellington and his granddaughters, we negotiated a 21-day time-limited trial beginning with an open repair of his aneurysm. However, we explained that his age and frailty put him at high risk for a number of complications, including death.

Following aortic repair, he seemed to do well initially, but a pulmonary embolus led to protracted ventilation further complicated by pneumonia and sepsis. After 10 days of IV antibiotics, bedside dialysis, and the ICU team's full court press, he started to stabilize and was eventually extubated. However, on postoperative day 15, he suffered a massive stroke that again required intubation to protect his airway. Although still within the negotiated time-limited trial, the stroke eliminated any realistic chance of achieving the patient's overarching goals, so together with the palliative care physician, the patient's surgeon, and daughter decided to withdraw support. The patient died shortly thereafter surrounded by his daughter, grandchildren, and the local parish priest. Although the team was not able to restore the patient to health, the care rendered and the decisions made were nonetheless a model of excellence.

Key Points

- *Ethical Practice Strives for "The Good."* All clinical decisions have ethical content – even if there is no dilemma – because all clinical decisions are directed toward the patient's good. The challenge is to discern the right and good clinical choice in the context of each patient's unique values.

- *Emergencies*: In clinical emergencies when patients cannot speak for themselves, vascular surgeons are empowered to make decisions on behalf of their patient based on the surgeon's good-faith understanding of the patient's good. This power is a heavy responsibility that should be exercised with extreme care, informed by growing data that older patients often receive more invasive and aggressive care than they would have wanted had they been able to speak for themselves.
- *Decision-Making Capacity*: When the patient is able to express an opinion, the vascular surgeon is tasked with assessing the patient's capacity to make the decision at hand. Capacitated patients (1) understand the surrounding circumstances, (2) appreciate that the risks, benefits, and alternatives apply to them, and (3) reason with the information they understand and appreciate to (4) express their preferred course of action.
- *Surrogate Decision-Making*: If a patient does not have capacity, advice from surrogate decision-maker (e.g., healthcare power of attorney) is sought. Surrogates are likely better informed than surgeons about patient values, but they are often inaccurate in predicting what patients would want if they could speak for themselves. It is appropriate to ask surrogates to explain why they think their choices serve the patient's good.
- *Shared Decision Making* combines the surgeon's clinical judgment with patient's values and goals. It recognizes that the surgeon's practical wisdom of experience (*phronesis*) uniquely positions him/her to recommend the option most likely to achieve a specific goal; and that the patient is uniquely positioned to establish the goals for surgical treatment.
- *Goals of Care* guide shared decision making, and they are most effective when they move beyond mere mortality and morbidity to describe in textured ways what it means for patients to flourish and how the proposed surgical treatment can serve that flourishing. Establishing the goals of care starts with the first clinical encounter, and in complex situations, palliative care consultants are often helpful in assessing patient goals. However, ongoing conversations between surgeon, patient, and surrogates are needed to reassess how goals and values change with clinical context. If the right and good choice of action is elusive, time is often best spent elucidating better understanding the goals of care.
- *Time-Limited Trials* are pragmatic tools for discerning the patient's good. In circumstances of diagnostic or therapeutic uncertainty, patients and surgeons can agree to pursue a specific course of action (e.g., initial surgery and 2 weeks of postoperative care) with a plan to reassess the likelihood of achieving the patient's goals at the end of the trial period. If the patient's goals are still achievable, a new trial can be established, but if the stated goals are no longer realistic, the best course of action may require withdrawal of support. Even though such patients do not survive, prudent withdrawal can nonetheless be a model of clinical excellence.

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