EPISODE – Author Interview: "***Where's the Value In Preoperative Covenants Between Surgeons and Patients?***"

Guests: Robert Ledbetter; Buddy Marterre, MD, MDiv
Host: Tim Hoff
Transcript by: Cheryl Green

Access to podcast

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TIM HOFF: Welcome to another episode of the Author Interview Series from the *American Medical Association Journal of Ethics*. I'm your host, Tim Hoff. This series provides an alternative format for accessing the interesting and important work being done by Journal contributors each month. Joining me on this episode is Rob Ledbetter, a fourth-year medical student at Wake Forest University School of Medicine in Winston-Salem, North Carolina, and Dr Buddy Marterre, an Assistant Professor of Surgery and Internal Medicine, also at Wake Forest University School of Medicine. They're with me to discuss their article, *Where's the Value In Preoperative Covenants Between Surgeons and Patients?*, in the October 2021 issue of the Journal, *Palliative Surgery*. Rob and Dr Marterre, thank you so much for joining me.

ROB LEDBETTER: Thank you for having us.

DR BUDDY MARTERRE: Thank you. Thank you so much for having us.

HOFF: So, to begin with, what is the main ethics point of your article?

LEDBETTER: The key ethical point that I think we're trying to address is, I guess trying to better understand how to treat patients. I think that's relatively easier said than done.

HOFF: Mm.

LEDBETTER: So, in the case of surgery, surgeons are fixers—which is something we say in the article—and they want to do the next step to make a patient better. But sometimes that step's not always as obvious as we would like it to be. So, we offer a series of phrasings to better illustrate what a patient ultimately wants rather than what they're saying.

HOFF: Mm.

LEDBETTER: And I think one of the things that we can really kind of key in on is the patient may say, you know, "I want to get better. If this makes me better, I will do it." But maybe what they want is to have the ability to still see their family or not live with a feeding tube or something along those lines.

HOFF: Mmhmm.

LEDBETTER: So, ultimately, what we're trying to do is use, I guess, phraseology to differentiate between what do you want immediately and what you want kind of long-term? And then, how do we best approximate that with the medical plan?

HOFF: Hmm. Great. Thank you. Dr Marterre, anything to add to that?

MARTERRE: Yeah, I would. I think when clinicians, and in the case of our article surgeons, offer what I call à la carte medicine and ask patients what they want, that perhaps surprisingly, that is not only counterproductive to honoring patient autonomy, it also disempowers the clinician or the surgeon in this case. Honoring autonomy requires eliciting and clarifying the patient's values and helping them reflect on their values. And shared decision making really should end with the clinician, in this case, the surgeon, making a value-congruent or value-concordant recommendation, which is almost the antithesis of the way surgery and medicine is routinely practiced today with that à la carte mentality.

LEDBETTER: And I think one thing we want to elicit is a better definition of autonomy as not simply getting what you want done, but also the ability to understand what you want done. So, the power to achieve and understand what you're doing.

HOFF: Sure. So, it sounds like we're getting to this point in the conversation already, but what is the most important thing, do you think, for health professions students and trainees to take from the article?

LEDBETTER: I would say that probably the most clinically relevant thing that we can pass on, besides just the conversation about autonomy, is trying to keep in mind what the patient is saying and what they mean. I think a lot of times we can use words to kind of ballpark what we're saying, and that usually gets the intent across in our social life because we don't really need a lawyer to kind of fact check what we're saying.

HOFF: [chuckles]

LEDBETTER: Usually we can get our point across. But I think in the medical setting where specifics really matter and the distinctions between plans have long-term effects, ballparking what we're saying doesn't really work and doesn't speak to patients' values. So, it's important to, whether you're taking a history to see what someone's trying to tell you why they're sick or when you're making a treatment plan that involves ethical quandaries, to really try to elicit what someone's trying to tell you rather than just assuming that they mean specifically what they're saying.

HOFF: Mmhmm.

MARTERRE: I would echo what Rob is saying, particularly about meaning and how important meanings are and specifically perhaps around the word "hope."

HOFF: Mm.

MARTERRE: The word "hope" gets thrown around a lot in medicine and surgery. And yet, I don't think people have, clinicians particularly, don't have a good understanding of what hope means. So, we try to clarify that in the article.

And I think also to Rob's point, the informed consent process for surgery, the way that's typically done, I believe, is actually flawed from an ethics standpoint, because it typically does not take into account the patient's existential fear.

HOFF: Hmm.

MARTERRE: It does not take into account any potential, or perhaps subconscious, fear that the surgeon may have of powerlessness or failure to make the patient better. It does not take into account the patient's values or what acceptable tradeoffs that they would be willing to acquiesce to, much less their unacceptable treatment burdens. We know that there are a lot of patients that would find going to a skilled nursing facility, either for a short term or perhaps for a long term, unacceptable—

HOFF: Mmhmm.

MARTERRE: —life support modalities they would find perhaps acceptable in the short-term, but certainly unacceptable in the long-term. And all of those types of things need to be clarified in the preoperative setting as well as investigate contingency plans. What if the surgery doesn't go as planned? What if we wind up with a result that we, you know, is less acceptable? What should we do under those circumstances? And clarify that kind of thing preoperatively before the patient is anesthetized and intubated and can't talk to us and express their values in a nuanced way.

HOFF: Hmm. Thank you. And finally, if there was another point that you could add to your article, what would that be?

LEDBETTER: I think one of the things that I found interesting about the topic of autonomy that I don't think we could elegantly include into this paper was the evolution of autonomy in the doctor-patient relationship since the mid-20th century. So, everything from the Civil Rights movements to the Vietnam War really affected the way that we see institutions in general, especially the medical institution. And that has led to a, I guess, more patient-centered...not necessarily patient-centered, but I guess the best way to describe it is like increasing the power of the patient in decision making.

HOFF: Mm.

LEDBETTER: So, drifting from like a paternalistic model of the pre-'50s to what I think we called à la cart medicine, where it's just you kind of present the patient with options, and they just kind of pick that, because I think that's a reaction to the paternalistic past of medicine. But it's not necessarily better. You know, even as someone who's three years into medical school, there's a lot of times when if I were presented with options, I wouldn't know what to do.

HOFF: Hmm.

LEDBETTER: So, just having the options doesn't necessarily mean you're getting a better result or acting more autonomously. Sometimes it just means you have more options.

HOFF: Sure. Dr Marterre?

MARTERRE: I don't think I could've said it better. I think that's perfect. I'm old enough to remember the paternalistic days.

HOFF and MARTERRE: [chuckle]

MARTERRE: And there were certainly a lot of problems with that end of the spectrum, if you will. But I also see a lot of problems with the current à la cart medicine or what we call, what one palliative care ethicist expert calls, “radical autonomy.”

HOFF: Mm.

MARTERRE: It’s just as injurious, I believe, not only to patients, but also to families, and frankly, to surgeons and clinicians. And we need a healthy, we need a very healthy center with shared decision making where the clinician is able to determine the values beneath or behind, if you will, the patient’s autonomy and make value-congruent recommendations and then carry them out on the patient’s behalf. That’s a lot easier said than done. It’s a very, very difficult, messy process, but hopefully the article that Rob and I wrote will help clarify it a little bit with some of the definitions that we give. [bright theme music returns]

HOFF: Well, thank you both for your contribution to this important conversation, and thank you both also for being on the podcast today.

MARTERRE: You are more than welcome. It’s our honor.

LEDBETTER: Yeah, absolutely. Thank you for having us.

HOFF: To read the full article and the rest of the October 2021 issue for free, visit our site JournalofEthics.org. We’ll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics*.