

Surgeons Take on End-of-Life Care

Dear Editor,

'End-of-life care' may be the buzz word in medicine these days and palliative care physicians, intensivists and geriatricians are seeing their fair share of such dying patients increasingly more as the population aged. Of all mortalities in our surgical intensive care unit (SICU), 50% of patients have 'do not resuscitate' (DNR) orders instituted in the chart.¹ Such decisions are usually made by the physicians in charge and the intensivist, in consultation with the patient or their families. Infrequently, an ethics consultation is made if there are any conflicts or if either the family or the physicians are in opposing views about a decision.² Most end-of-life decisions are made for patients in whom further care is deemed 'futile', or if the postoperative course has taken a turn for the worst, and there is little hope of survival. Advanced directives are at present not instituted and seldom is there a 'living will' of the patient available. Most patients are moribund and do not have the cognitive ability to make a calculated decision for themselves. Often, the families are in no right frame of mind to actually make any decisions at such times when dealing with the shock and grief of what is happening to their loved ones.^{3,4} The entire burden therefore of making such an important decision falls on the shoulders of the caregivers in consultation and according to the wishes of the families. There are many ethical models of such decision-making such as paternalistic or a combined family-physician decision.⁵ However, this is often a very vague and problematic area where clear-cut guidelines are not present. Each decision varies with the particular circumstance, the medical condition, and the age, the ethical, moral and religious beliefs of the next of kin, the patient as well as the physician.

Surgeons have traditionally been averse to operating on cases where patients or loved ones will readily approach end-of-life care soon after surgery, especially if the operation is technically challenging.⁶ Making end-of-life decisions are difficult and approaching the topic may be seen as abandonment. There is a big gap in the specific training of physicians in matters of family communication, joint decision making and implementation of ethical end-of-life decisions.⁷ The intricacies that arise in these scenarios are many and surgeons are often conflicted as shown in previous studies.⁸ Some studies have studied this issue in

a physician cohort.⁹ For instance, Keating et al⁹ observed that most physicians delay end-of-life discussions, even in terminal patients, until care becomes futile or patients decompensate. They suggest more research is needed to understand the physician's reasons for timing of discussions.

Materials and Methods

Our aim was to determine the scope of end-of-life care practised by surgeons and their comfort level at our institution, and to compare this with results of other studies observing timing and comfort of doctors in other specialties and surgeons in other countries making such decisions. Our hypothesis is that regional and training differences exist amongst doctors regarding the timing and institution of end-of-life care. By means of an anonymous online survey using Survey monkey[®], we surveyed 22 registrar and above surgeons in our setting. Our response rate was 50% and 100% of the responders completed the survey. The survey comprised 10 questions: 6 were yes/no choices, 3 were multiple-choice answers and 1 was open-ended. In our institution, there exists an extent of care form that is to be filled when declaring a patient is 'dangerously ill' and the extent of care to be carried out, such as 'do not resuscitate' or 'withdrawal of care' or 'comfort care'. The names and roles of the participants in the discussion must be entered and the form signed.

Results

All our participants were practicing surgery in Singapore. They had all completed their junior level training and would be in direct contact with the families of patients in a responsible capacity. Their ethnic origin remained unknown as it was an anonymous survey. In all, 84.6% of the responders stated they had participated in 'end-of-life care' while 69.2% of them said they had personally made a DNR decision. However, a large majority (76.9%) said they had received no formal training in end-of-life care. The ones that stated they had were trained in the United States (US) system. Only 69.2% of the surgeons said they felt comfortable making such decisions. Of the reasons chosen for not feeling comfortable, 25% of them cited 'ethical reasons' while another 25% of them cited 'fear of

law suits'. In total, 75% of them were 'unsure' and none of them cited religious reasons. A vast majority (76.9%) did not rely on the Ethics committee routinely for their decisions, however, 23% of them said they did consult the opinion of an ethics committee routinely. A total of 69.2% of respondents said they had reversed some DNR decisions in the past. All of them (100%) chose the reason that the 'patient's condition improved' for their reversal. However, 66.7% of respondents also chose that the 'patient's family changed their minds'. When asked 'Why do you make DNR decisions most often?', 100% of them said 'when there is a futile outcome' while 46.2% of them also chose 'when the patient is brain dead' and an equal number (46.2%) said 'when the family does not want to be aggressive'. Also, none said it was due to 'financial or social burden'. Other studies done in the past have been carried out in western countries and therefore we surmise that cultural differences exist amongst doctors in end-of-life care institution and also the type of training one receives.

Limitations

There are many limitations to this study. It is a small cohort, with only a 50% response rate. Compared other countries or specialties, the study population could be very different and institutional guidelines governing end-of-life discussions may also play a large role in the practices. However, this is a unique study amongst Asian surgeons of their conduct in this very essential role. We are unable to surmise whether the surgeons routinely reversed their DNR decisions in 69% of cases as they were unsure of their initial decisions or whether there existed valid reasons, and in the case where the answer was due to family changing their minds, were the surgeons agreeable to this in their judgement to make a wise decision.

Conclusion

In the face of an ageing population, the role of end-of-life care is even more pronounced and surgeons have to equally share this burden of decision making with all other care givers and families. Our statistics show that the rate of such decisions is high. Many feel they are comfortable with such decisions and their reasons for making such a decision fit in well with the principles of ethics.^{10,11} However, some are not comfortable with making these decisions. This could be a lack of formal training or personal views. Our statistics show that unlike the West, the surgeons are quite ready to make patients DNR if the appropriate scenario arises. They also have reversed their decisions frequently. This may mean either a wrong decision was made prematurely or the situation changed. Further and larger studies are required to understand the particular specifics of end-of-life care

decisions amongst this cohort. The Mental Capacity Act in Singapore defines the role of the family in the decision-making process for an individual who is unable to make lucid decisions for himself. We recommend incorporating end-of-life awareness and training for undergraduates as well as in the training of people who will be primarily making such decisions, such as surgeons and a broader awareness of the Mental Capacity Act in Singapore in a local context.

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Shahla Siddiqui, ¹MBBS(Pak), DABA(USA)

¹Department of Anaesthesia, Khoo Teck Puat Hospital, Singapore

Address for Correspondence: Dr Shahla Siddiqui, Department of Anaesthesia, Khoo Teck Puat Hospital, 90 Yishun Central, Singapore 768828.
Email: shahlasi@yahoo.com