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Invited Commentary

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In this issue of the *Journal of the American College of Surgeons,* Drs Eachempati, Miller, and Fins revisit the drama of SICU care at the end of life, explore the roles of the dramatis personae, and propose that the surgical intensivist mediate conflicts that play out among caregivers and families.

The players are familiar: a patient who has chosen to live free of life support, or die; some caregivers who see a patient too sick to live while others think the patient too well to die; and a family trying to grapple with the moonscape of the ICU. The drama is familiar: a surgeon invoking the slimmest hope for recovery; the family struggling to comprehend what is seen and heard; a crisis that juxtaposes ambiguities of the moral world ("Is this what our loved one wanted?") with the technical world ("There might be a chance if you hang in there just a little longer and let us try another treatment . . . ");[1] a consensus that limits time, aggressiveness, or both; and the death of the patient. What is new in this retelling is analysis and a proposed resolution.

The covenant of care

The authors opine that the surgeon-patient relationship differs from the relationship that a patient has with the physician. That a difference exists cannot be denied. The authors suggest that the obligations of a surgeon to the patient change—or at least are perceived to have changed—after an operation is performed. Here, we disagree. We have elsewhere suggested that the nature of the surgeon-patient relationship is covenantal, and that surgery (or the decision not to operate) simply fulfills surgeons' unilateral promise to patients: "I will care for you."[2]

The notion that surgeons pursue quixotic postoperative care simply to avoid appearing at a morbidity and mortality conference or to improve outcomes reports seems difficult to support. Surgeons are never forced to operate, and better outcomes can always be assured by selectively operating on low-risk patients, yet risky procedures are commonly performed. Prominent surgeons state that they would violate expressed wishes of a patient not to undergo amputation if those surgeons thought amputation was in the patient's best interest; they would take on the risk even if the patient categorically refused to consider surgery.[3] To break the covenant of care—to abandon the patient at the hour of greatest need while others argue to let the patient "die with dignity"—is more shameful than even the failure of the surgeon to accomplish the "expected miracle."[4,5] So it is hardly surprising—indeed it is somewhat reassuring—that surgeons so strongly resist revising the goal of care from "cure" to "comfort."

The need for mediation

The authors suggest mediation as a route to resolution of conflicts that surround end-of-life care, and further suggest that the surgical intensivist is generally well positioned to serve as mediator. Whether the activity at an end-of-life conference is more mediation or facilitation is a heuristic as much as a semantic distinction: conflict resolution generally does not occur without a guided discussion of possible interventions and outcomes. Mediator or facilitator, someone needs to play that guiding role. The SUPPORT study suggested that it should not be a nurse, and there are other studies that suggest that a physician is probably best suited to facilitate discussions of such complex topics.[6,7]

The question is, which physician? We disagree that the surgical intensivist is commonly seen as an unbiased

authority. Bias enters the discussions because the surgical intensivist has an additional ethical obligation, namely, fulfillment of the ethical principle of distributive justice. Critical care resources are not only expensive, but also scarce. Although the surgeon bears responsibility to a single patient occupying a bed in the ICU, the surgical intensivist is obligated to do the greatest good for the greatest number, including patients who could benefit from critical care but cannot access it because the unit is full. Authority enters the discussion because the population of surgical intensivists typically includes nonsurgeons (usually, anesthesiologists) and young surgeons. A senior surgeon with a patient "in trouble" may seek advice from many physicians, but generally takes advice only from another, more senior, surgeon. An alternative untested approach would appoint a senior surgeon, trained in medical ethics and uninvolved with the direct care of the patient, to serve as facilitator at end-of-life meetings among families and caregivers.

A heart of wisdom

End-of-life episodes in the SICU are increasing, driven in part by the aging of the population and in part by breathtaking advances in surgical care. Surgery is helping Americans live longer and more productive lives. Yet just as death is inevitable, so are the uncertainties surrounding end-of-life decisions we make on behalf of our patients and their families. These uncertainties should not make us uneasy. They are as much a part of end-of-life decision making as science and experience.

Living—and dying—with uncertainty also requires faith. Moses' prayer, the oldest Psalm in the Psalter, is perhaps as relevant today as it was 3,500 years ago. We still have as much to learn about how to number our patients' days, and our own.

> The length of our days is seventy years—or eighty, if we have the strength; yet their span is but trouble and sorrow, for they quickly pass, and we fly away . . . Teach us to number our days aright, that we may gain a heart of wisdom.[8]

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