Dear Ethics Committee Members,

What follows is an ethical discussion of how to handle an intraoperative consult. This arose from a question about our statement on informed consent. This topic was too large to be addressed in a single line or two in our informed consent document, which is why it is presented in a separate document.

I developed the concepts in the document and had them evaluated by Phil Shadduck over a year ago. Unfortunately, it took me some time to revisit this due to several changes in my life.

First, I would appreciate any input you have on the document. Second, the document does not include my endnotes yet, as I have not added them. This will be done along with any changes you suggest. Third, the chart at the end of the document may need to be updated to reflect the final language. I edited some parts of the document, but I haven't reviewed the chart again, which can be done if you suggest changes. Finally, this will be presented to the Board for approval for publication after we have finalized the document.

Unfortunately, I will be traveling for my current job and probably won't be available for the committee meeting. (Bummer!)

I do look forward to your input so we can get this to the board.

Thanks,
Arthur Rawlings

Informed Consent and the Intraoperative Consult

Preamble

This statement on informed consent during an intraoperative consult, developed by the SAGES Ethics Committee, has been reviewed and approved by the Board of Governors of SAGES. It provides a framework for conducting an intraoperative consult and evaluating that process afterward, with a particular focus on informed consent. This statement adds to our previous guidance on informed consent, which deliberately did not address the intraoperative consult due to its complexity.

Introduction

Informed consent has a rich history in the field of medicine and is now a crucial part of daily practice, especially in surgery. Many countries, including the United States, require informed consent before a procedure. This process encourages ethical patient care and should be performed even when not legally or institutionally mandated. Legal requirements for informed consent vary by state and country, and healthcare systems often have their own specific rules. All practitioners should familiarize themselves with and follow the applicable laws and policies, and go beyond these standards if they believe it is ethically right. While the importance of obtaining

consent before a procedure has been widely discussed, and resources on this are readily available, the implications of consent during intraoperative consults have not been as thoroughly explored. This statement aims to help surgeons and institutions develop a framework for considering the patient's consent during intraoperative consultations.

Addressing Unexpected Situations

This statement addresses intraoperative consultations that are unplanned events. Some aspect of the procedure unexpectedly prompted the consult during surgery, so no preplanning with the patient, the primary surgeon, or the consulted surgeon was possible. There are procedures in which discussions are held with the patient before surgery to determine if additional assistance might be needed based on intraoperative findings. This situation falls under our previous statement on informed consent, where the primary surgeon, the consulted surgeon, and the patient reach a mutual understanding of how to proceed depending on intraoperative findings. This statement only focuses on unanticipated consultations prompted during surgery. It also assumes that the patient cannot provide verbal consent at that time. In some cases, such as procedures performed under local anesthesia, the patient remains capable of participating in ongoing dialogue with the primary surgeon. In such cases, the patient can give informed consent during the intraoperative consult and is not part of this discussion.

Three Phases of the Intraoperative Consult

The unexpectedly prompted consultation during surgery is best broken down and analyzed into three phases. Each phase has specific practical and ethical considerations. The aspects within each phase are also independent. What happens in one phase does not necessarily determine what happens in the next, although it can influence subsequent phases. Viewing the intraoperative consult as a single event may overlook essential nuances necessary for developing this framework, making the examination of individual phases valuable. Surgeons should familiarize themselves with this model so they can apply it when unexpected events occur during surgery. Those reviewing an intraoperative consult afterward can also use this framework to assess the ethical aspects of the process.

Phase 1: The Initiation of the Intraoperative Consult

During an unexpectedly prompted surgical consultation, a prompt for the consultation is necessary. The first step involves understanding the reasons behind the intraoperative consult and identifying any unique ethical considerations that may be involved. Before examining the specific reasons for calling an intraoperative consult, it is important to state the value of such a consultation.

Before the operation, the primary surgeon and the patient entered into a new professional commitment in which the surgeon agreed to provide care for the patient according to the mutually agreed-upon goal of that surgery. If, during the operation, the primary surgeon is concerned that the mutually agreed-upon goal cannot be achieved due to a lack of knowledge or skill, an intraoperative consult is encouraged and ethically appropriate. The most crucial activity in the operating room is caring for the patient. The primary surgeon should have a low threshold

for initiating an intraoperative consult when that resource is available. When the primary surgeon lacks the necessary knowledge or skill to meet the mutual goal of the operation, the patient's needs take precedence over the surgeon's pride, and failing to initiate an intraoperative consult could be a breach of the agreed-upon goal. In short, a low threshold for calling an intraoperative consult is strongly preferred over a high threshold to do so.

There are at least five reasons to initiate an intraoperative consult. The primary surgeon provides the best service to the patient and the consulted physician when the reason for the consult is specific. This ensures clear communication between the surgeons and smoothly transitions into the second phase of the intraoperative consult process. The five reasons for an intraoperative consult are:

1. Confirmation of case progression. There are times when an encouraging word or a second opinion can be helpful to the primary surgeon. Am I making progress? Did I miss anything? Do I need to do anything else? Whether due to a lack of knowledge, experience, or the complexity of the case, these questions can arise in the primary surgeon's mind. These questions should not go unanswered. Sometimes, a phone call to a colleague can provide the answer. Other times, it is best to ask another surgeon to come into the operating room and review the work done so far. The key point is that if the primary surgeon is seriously questioning, do not leave the operating room until those questions are answered.

2. More challenging than initially anticipated. There are instances where, due to the complexity of the case or the experience level of the primary surgeon, a colleague is called bedside to assist. This intraoperative consult serves more than just reassurance; it helps confirm case progress. In such situations, an extra set of skilled hands is necessary. The primary surgeon may require better assistance to move forward or may need to aid a more experienced colleague through the difficulties encountered. Case complexity varies, and one is always entitled to request help during the procedure when they believe it is necessary.

3. Unexpected finding. There is potential to discover something new, something beyond the primary surgeon's knowledge and skill. Calling a colleague with the necessary expertise to the operating room may be needed to address this unexpected finding. Not all unexpected findings require an intraoperative consult, as some do not need immediate attention. Sometimes, documenting the finding and referring the patient to the appropriate colleague after surgery is the best approach. However, there are occasions when addressing the unexpected finding during the initial operation is in the best interest of the patient, and in those cases, an intraoperative consult should be initiated.

4. Unexpected complication. Not all surgeries go as planned. No ethically sound surgeon intentionally starts an operation aiming to harm the patient. However, virtually every well-meaning surgeon has experienced an operation where an unplanned and unwanted injury to a structure occurs. The primary surgeon might have the knowledge and skill to manage the intraoperative complication, and no intraoperative consult may be necessary. But if the complication exceeds the primary surgeon's expertise, an intraoperative consult should be called. When unplanned and undesired injuries happen, the primary surgeon should be praised for

recognizing and managing the injury properly. Calling in a colleague to assist shows the focus remains on patient care and honest recognition of one's limits.

5. Acute loss of the surgeon. This is a rare event, but the primary surgeon may not be able to continue with the surgery due to an acute illness, such as a stroke or myocardial infarction, during the procedure. In the case of complete acute loss of the surgeon, the operating room staff is responsible for calling another surgical colleague to the bedside to take over the case.

Phase 2a: The Acceptance of the Intraoperative Consult and Negotiation of Goals

The second phase of the intraoperative consult is best understood by dividing it into two parts. The first part, 2a, involves the acceptance of the intraoperative consult by the consulted surgeon, with negotiated goals for the consult between the two surgeons. This negotiation is often not even recognized in daily practice, but it occurs during the consultation. A primary surgeon needs assistance and contacts a colleague who provides the requested help. Just as initiating an intraoperative consult should have a low threshold, a consulted surgeon should have a very good reason to refuse assistance. The second part, phase 2b, involves obtaining patient consent for the consulted surgeon to be involved in the patient's care. The component in phase 2a, acceptance and negotiation of goals, can fall into one of five categories.

1. Complete the original procedure with the help of the consulted surgeon. This can be done through verbal guidance via phone or in person. The primary surgeon might only need verbal confirmation that no further action is required to finish the procedure. Alternatively, the consulted surgeon may need to visit the operating room to inspect the work and give approval. The primary surgeon might also require an additional skilled assistant to help complete the procedure. Everything depends on the unresolved questions and the needs of the primary surgeon who requested the consultation. In all cases, the goal of the consultation is to collaborate in finishing the original procedure with the assistance of the consulted surgeon.

2. Complete the original procedural goal with an unrelated additional procedure. An unplanned injury to a structure beyond the primary surgeon's knowledge and skill may occur. In such cases, an intraoperative consult might be necessary to address the injury, which is unrelated to the original objective but essential to proceed with the case. After repairing the injury, the primary surgeon can then resume and finish the original procedure.

3. Conclude with a change to a new objective. Unexpected findings or unplanned injuries may alter the course of the procedure. The original case goal should be abandoned during the consult, and the case should shift in a new direction. For example, an unexpected finding might change the goal from a curative to a palliative procedure. Alternatively, if the injury is severe, the original objective should be abandoned to focus on addressing the injury for the patient's benefit.

4. Abort the original objective of the procedure without additional steps. Unfortunately, unexpected findings in the operating room can lead to abandoning the original goal. Terminating a procedure is common when some types of metastatic cancer are discovered, and usually, an intraoperative consult is not necessary. There are situations where it is uncertain whether to

continue with the operation. In such cases, it is reasonable to call a colleague to the operating room for a second opinion before abandoning the procedure.

5. Proceed with the planned procedure, adding an additional step to help achieve the original goal. Sometimes, unexpected findings or an unplanned injury do not require aborting the case's original purpose, but they may cause a detour. You might need a colleague's help to address the unexpected finding or repair the unplanned injury. Once that has been handled, the case can continue toward the initial planned goal.

In negotiating one of the five goals for the intraoperative consult, there are four questions that help determine whether to proceed. First, is the procedure progressing in line with its original goal? If proceeding is entirely consistent with the original objective, the patient has already consented to that procedure. The only additional component is the consulted surgeon. Granted, the patient and the consulted surgeon did not establish a professional obligation beforehand. However, in this case, the new professional obligation is between the primary surgeon and the consulted surgeon. The goal of the procedure remains unchanged. The resource, specifically another colleague, needed to achieve that goal, has changed.

Second, is proceeding necessary to save the patient's life or limb? If it is not expected that the patient's life or limb is in significant danger for this procedure, but an unexpected finding or complication puts them in immediate peril, then proceeding is appropriate.

Third, does proceeding pose minimal risk to the patient? An unexpected finding may be treatable by surgery. However, the surgery required might carry a significantly higher risk of morbidity and mortality than the planned operation. If such contingencies were not discussed between the patient and primary surgeon before the procedure, aborting the operation may be ethically prudent, especially if a future procedure does not substantially increase the patient's risk or mortality.

Finally, does not proceeding with the potential for a future operation entail a higher risk than proceeding? There is a possibility of discovering an intraoperative finding that does not pose an immediate threat to life or limb. However, not proceeding could significantly raise the patient's risk based on the likely consequences of leaving a finding untreated.

Phase 2b: The Intraoperative Consult and Patient Consent

When the primary surgeon requests an intraoperative consult, they are making a paternalistic decision with the patient's best interest as the main concern. Such paternalism is unavoidable, and as mentioned above, intraoperative consults are encouraged to benefit the patient. Even though the patient cannot provide consent at the time of the consult, three scenarios must be considered.

1. The primary surgeon acts as the surrogate decision maker. In an unplanned injury, for example, the primary surgeon might decide that repair is necessary to save the patient's life or limb. This repair, in itself, may not be related to the goal of the procedure, but it significantly impacts the patient's future. In an urgent or emergency situation, involving other surrogate

decision makers might only delay treatment, risking the loss of a limb or even life. In such cases, the primary surgeon serves as the surrogate decision maker for the patient.

2. The patient's available representative acts as the surrogate decision maker. Not all unexpected findings or injuries require immediate attention. There may be time for the primary surgeon to speak in person or by phone with the patient's available representatives to discuss what happened and gather their input on how they believe the patient would want to proceed.

3. The patient is the decision maker. This may seem counterintuitive for this discussion, but the possibility of aborting the procedure, waking the patient, and having a discussion later about their preferences should not be overlooked. There are unexpected findings, for example, that do not require immediate attention but could increase morbidity and mortality if addressed surgically. If the finding does not need urgent attention during surgery and delaying treatment would not significantly raise the patient's risk, then it may be appropriate to discuss options with the patient at a later time. The surgeon might face criticism from patients for not proceeding with the procedure initially, but this should not prevent the surgeon from aborting the procedure and scheduling the discussion.

Phase 3: What are the Continuing Roles of the Primary Surgeon and the Consulted Surgeon after the Procedure?

The final phase of the intraoperative consult centers on the postoperative care of the patient. The intraoperative consult has introduced an unplanned physician into the patient-physician relationship. Clarifying all the roles and responsibilities for the surgeons, as well as properly documenting the procedure and those roles and responsibilities, is crucial for the ethical care of the patient. This final phase is also best explained in two parts.

Phase 3a: The possible continuing roles of the primary and consulted surgeons after the operation.

There are four potential ongoing roles for the primary and consulted surgeons after the case. Clarifying team member roles immediately after the case ensures patient care continues without delay. Additionally, documenting these roles is crucial for other members of the patient care team to understand who is responsible for each part of care. The four possible roles of care are:

1. The primary surgeon maintains primary care and responsibility for the patient. The consulted surgeon may have only provided advice or assistance during the operation. There is no necessity for the consulted surgeon to continue caring for the patient if the primary surgeon has the knowledge and skills to manage the patient postoperatively.

2. The primary surgeon and the consulted surgeon share responsibility for the patient's care with a common goal. The primary surgeon may have expertise and skills, but requires ongoing reassurance from a more experienced colleague as care continues. Clarifying who is ultimately responsible for decision-making regarding the patient is essential for overall care.

3. The primary surgeon and the consulting surgeon share responsibility for different aspects of the patient's care during the procedure. For example, the primary surgeon may be in charge of colonic anastomosis, while the consulting surgeon handles the repaired ureter. Clearly specifying whom to contact if patient care concerns arise is essential for the ongoing management of the patient by the surgical team.

4. The consulted surgeon takes primary care of the patient. The unexpected finding or unplanned injury may require a more complex or different procedure than initially planned. For example, if the consulted surgeon assumes primary responsibility in the operating room for managing an injury outside the knowledge and skill of the primary surgeon, the consulted surgeon could take primary care of the patient.

Phase 3b: The disclosure and documentation of the intraoperative consult

Finally, the primary surgeon is responsible for communicating with the patient's representatives and the patient about what occurred in the operating room, why the intraoperative consult was needed, and the care plan after the procedure. The consulted surgeon is also responsible for documentation and disclosure of involvement in the case.

The primary surgeon has a duty to document the events leading up to the intraoperative consult, the reason for the consult, and the negotiated plan with the consulted surgeon. After the procedure, the primary surgeon should also record the discussion with the patient's representatives and the patient regarding what happened and how the patient's care will continue. This includes a statement about the involvement of the consulted surgeon during and after the operation.

The surgeon who was consulted must explain the reason for the intraoperative consultation and summarize the findings at the beginning of the case. The operative report of the surgeon consulted should specify the events from the consultation until the consulted physician is no longer involved. It is inappropriate to make judgments about events before involvement in the case since they were not directly observed. The primary surgeon is responsible for describing what led to the intraoperative consultation. While the primary surgeon documents the patient's care progression, the consulted surgeon should also acknowledge how the care plan was decided between the two surgeons.

Conclusion

Informed consent for an intraoperative consult involves multiple aspects. Three main stages comprise the intraoperative consult: the initiation of the consult, the negotiation of care, and the planning for post-operative care. Each stage is somewhat independent and requires proper attention to ensure ethical patient care.

Phases of the Intraoperative Consult
Phase 1: Why is the intraoperative consult initiated?
1. There is needed confirmation of case progression. 2. The case is more difficult than originally expected. 3. There is an unexpected finding. 4. There is a complication. 5. The surgeon became incapacitated.
Phase 2a: What are the negotiated goals for the consult?
1. Finish the original procedure with the benefit of the consulted surgeon. 2. Finish the original procedural objective with an added procedure with no connection to the original surgical objective. 3. Finish with an alteration of the case to a new objective. 4. Abort the procedure's original objective with no additional procedures. 5. Proceed with the planned operation with an added procedure to help accomplish the original case objective.
Phase 2b: How is the decision made to progress?
1. The primary surgeon functions as the surrogate decision maker. 2. The patient's available representative functions as the surrogate decision maker. 3. Additional procedures are postponed until the patient can make a decision.
Phase 3a: What are the continuing roles of the surgeons after the procedure?
1. The primary surgeon retains full responsibility for the patient. 2. The primary and consulted surgeons share care for the patient. 3. The primary surgeon and consulted surgeon share care for the patient for different aspects of the procedure. 4. The consulted surgeon assumes primary care for the patient.
Phase 3b: How was the intraoperative consult communicated and documented?
1. The primary surgeon documents a. the events leading up to and the reason for the intraoperative consult, b. the agreed upon roles for the primary and consulted surgeon, c. the disclosure to the patient and the patient's representatives of the intraoperative consult, and d. how ongoing patient care will be managed. 2. The consulted surgeon documents a. the reason for the intraoperative consult, b. the findings when entering the case, c. all involvement of the procedure while present, and d. the ongoing role, if any, after the procedure.