Should This Operation Proceed? When Residents and Faculty Disagree During the COVID-19 Pandemic and Recovery

Jennifer Tseng, MD,✉ Kevin K. Roggin, MD, and Peter Angelos, MD, PhD

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At the start of the COVID-19 pandemic, nonurgent elective surgeries were recommended to be postponed.[1] Now, as hospitals across the country have seen their COVID-19 numbers stabilize with additional supplies in place of personal protective equipment and ventilators, attention has turned to how institutions will recover. As surgeons, we must make decisions about which operations are medically necessary and time sensitive to proceed ahead during this ongoing uncertain period.[2] Previously redistributed resident physicians are being repatriated back to surgical services as operating rooms start to schedule more cases again.

However, there have been cases of poor surgical outcomes for patients who were preoperatively known to have COVID-19 or were found to be infected after an unexpected postoperative decline.[3] When a patient has an operation that could have been postponed and suffers significant morbidity or mortality related to COVID-19, his or her surgeon suffers significant moral distress. Residents, as proxy for their faculty member, are obligated to carry out a disproportionate share of patient care in a clinical setting of heightened risk and uncertainty in the transmission and outcomes of COVID-19 infection. Residents may struggle with the obligation of nonmaleficence (the duty to avoid harming their patients) and believe, at the acceptable cost to patient autonomy, that a patient should be dissuaded from having surgery during this high-risk time period. This raises several questions including:

- How has the COVID-19 pandemic changed resident-faculty dynamics and communication about a patient's indications and suitability for surgery?
- What factors contribute to resident disagreement with the risk-benefit assessment that the attending surgeon has made regarding the value of moving ahead with surgery?

It must be acknowledged that resident physicians are frontline providers in academic institutions and have a different perspective on the COVID-19 pandemic than surgical faculty members who are increasingly off-site these days due to guidance for social distancing. Communications occur through telephone or videoconferencing instead of in person. Residents are more isolated from faculty members and each other which may lead to residents feeling that they are being put in harm's way whereas faculty members are protected.

Surgical residents, if not reallocated to COVID-19 units in heavily hit areas, are completing consults in emergency rooms and intensive care units where they encounter very sick COVID-19 patients. They are on-site and aware of the devastating nature of severe COVID-19 when they witness themselves or hear from colleagues and friends about the tragic experiences of working in the COVID-19 units. The increased frequency of hospital overhead respiratory codes related to COVID-19 likely adds to the psychological toll for any working surgical resident. Residents undoubtedly have a more visceral reaction to thinking about a well patient taking the risk of COVID-19 infection to have an operation now that was previously considered suitable for delay.

Additionally, as many programs have shifted residents away from outpatient clinics to needed inpatient coverage, residents lack the continuity of preoperatively meeting the patient at initial consultation and understanding the back story and reasoning behind not only why an operation is scheduled but also why it is scheduled during the COVID-19 crisis and not postponed until a later, possibly less risky time. With hospitals recovering from the peak surge of infection cases, operation scheduling is ramping up during an interval when patient safety with respect to COVID-19 remains uncertain. As residents may miss some of the nuances of clinical determinations, conflicts may increase due to their not being part of the decision-making process and yet still being asked to participate in the operations or explain things to patients with whose decisions they may disagree. As the recovery from COVID proceeds, residents may be increasingly placed in the position of reassuring worried patients about surgical practice and outcomes even as they have their own concerns about the impact of COVID-19 on operative risks, long-term morbidity, and on chronic diseases such as cancer.

There is also a hierarchy between surgical faculty and residents as part of training. Due to the power discrepancy, residents may feel uncomfortable raising concerns about whether a patient is a suitable candidate for surgery or feel their opinion may not influence the decision-making process. Residents may feel torn between caring for the patient and their accountability to their faculty member who holds the power of influence (eg, through evaluations of performance, assessments of training competencies, and decisions on promotion). Residents may stay silent about personal qualms related to risk to the patient, colleagues, themselves, and in turn their loved ones at home for the collective benefit of the residency program, in the mentality of ''taking one for the team.'' Perceiving a lack of justice, residents may feel that a patient and associated operation is an unsuitable use of scarce personal protective equipment, intensive care unit beds, and provider time. Residents may notice the economic tension hospitals face to maintain viability during the COVID-19 crisis and assume that surgeries are being scheduled primarily to generate revenue for the institution and the surgeon. Furthermore, faculty members may have the benefit of the most up-to-date information from hospital leadership that is not available to residents. This information differential may lead to discrepant levels of understanding between faculty and residents about the public health implications of performing surgery.

From the Department of Surgery, The University of Chicago Medicine, Chicago, Illinois.
✉jtseng@surgery.bsd.uchicago.edu.
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Surgical residents by nature of their specialty need to have a certain amount of conviction in their abilities to do their jobs well. COVID-19 has been a significant time of uncertainty, undermining the confidence of not just the practicing senior faculty member but also the surgeon-in-training. Thus, training programs should carefully consider initiatives to restore resident confidence and provide them with an honest and unafraid voice that can bridge potential fractures in the resident-faculty relationship. Recommendations include the following:

- Facilitate open dialogue between residents and faculty through forums such as moderated ethics videoconferences and dedicated didactics related to COVID-19 topics.
- Bolster peer support groups within the residency with a variety of faculty mentors who can act as resident champions if ethical dilemmas need to be addressed at the program level.
- Reintegrate residents into the preoperative decision-making process through involvement in virtual patient consultations and in multidisciplinary and preoperative planning conferences.
- Adjust faculty teaching scripts to help residents understand not just how a decision for surgery is made but correspondingly why a surgery is proceeding ahead during the COVID-19 pandemic despite additive risks.
- Solicit resident input and feedback in creating and instituting COVID-19 era patient safety protocols and infection control best practices with the perioperative management of patients.
- Empower residents to initiate or replicate surgical informed consents with COVID-era adjustments[4] and encourage residents to address goals of surgical care and code status with patients upfront.
- If a resident refuses involvement in an operation, allow for accommodations within reason as the resident may be signaling moral, ethical, or physical distress that needs to be further addressed outside of patient care settings.

The COVID-19 pandemic has had a profound impact on the entire population. It has resulted in disruptions in the usual care of surgical patients and in the education of surgical residents. As we proceed into the recovery phase, surgical faculty must take efforts to ensure that as we are restoring usual patient care processes we are also restoring the trust of our surgical residents. In the long run, the health and safety of the population will depend on how well we continue to educate the next generation of surgeons in the complexities of ethical decision-making even in the face of so many uncertainties.

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