Who Should Manage the Dying Patient?: Rescue, Shame, and the Surgical ICU Dilemma

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Advances in surgery and critical care have extended our therapeutic options and the range of patients offered those options. Physiologically brittle patients, including the elderly and the chronically ill, are operated on with increasing frequency using progressively complex procedures. Nearly all initially survive their operations. Complications are infrequent. But when complications occur, they can accumulate and inexorably culminate in the death of the patient, despite the application of aggressive, even heroic, interventions.

The accumulation of complications triggers powerful responses in patient and surgeon alike. The focus of this article is the psychology of the surgeon and the consequences of projecting that psychology through hierarchical power relationships to the rest of the healthcare team, to the patient, and the family members. As Bosk[1] observed in his ethnographic study of surgical services, one characteristic that sets the surgeon apart from his or her medical colleagues is his or her exaggerated sense of accountability for the patient's outcomes. Surgeons use a special forum for discussion of adverse outcomes, death, and complications (more colloquially, the morbidity and mortality [M and M] conference).

What is unusual is not the existence of the forum, but the specific question that is usually asked of the surgeon whose patient has died: "What did you (or didn't you) do?" Other members of the medical profession typically ask, "What happened?" but surgeons are trained to hold themselves entirely accountable for the outcomes of their patients. To acknowledge technical or judgmental error is taken as a sign of maturity, while regular attribution of a poor outcome to "patient disease" is regarded as inconclusive, or worse, a sign that the surgeon is unwilling to accept responsibility for the adverse outcomes. Errors in the role of surgeon—technical and judgmental—are forgivable by the community of peers. Errors in assuming the role of surgeon, such as failure to accept responsibility for one's patients, are not forgivable. Small wonder, then, that the surgeon who "puts on the hair shirt" in the M and M conference, but is unable to identify the pivotal error, will throw himself or herself to the mercy of the audience and ask, "What should I have done?" Absolution requires the identification of a forgivable error.

The second element in the psychology of the surgeon relevant to the management of the dying patient is what Nuland[2] terms the "rescue credo." In the summary chapter of his book, *The Lessons Learned*, Nuland reviews the course of an elderly woman with an abdominal catastrophe who stated that she did not wish to be intubated and operated on. The author then repaired a perforated ulcer and she recovered, only to sustain a massive stroke 2 weeks later. Musing first that he should have respected the patient's wish not to be operated on, Nuland discards this idea as unrealistic because, had he failed to operate, he would have been severely chastised by his colleagues at the subsequent mortality conference. He states that his colleagues would hold the surgeon responsible for persuading the patient to accept an operation that was potentially life-saving. In the surgeon's mind, the Hippocratic imperative to "First, do no harm" is more properly interpreted as "First, do not allow the patient to die." The modern surgical ICU (SICU) version is articulated by surgical residents as the alliterative, "Keep him alive 'til seven-oh-five" (when shift changes occur).

As Katz[3] (among others) points out, the surgeon assumes a heroic posture, perceiving that he or she fights a solitary battle against disease. Indeed, even during re-

cruitment and selection of surgical trainees, faculties will often pose a clinical problem for the candidate to solve. In its classic formulation, the problem is framed as a page to the sleeping intern from a nurse who observes that a particular postoperative patient "does not look right." The medical details of the problem are less relevant than the immediate reply that the interviewer seeks, namely a visceral response by the candidate to get out of bed and go see ("rescue") the patient. Candidates who do not voice an immediate decision to physically attend the patient are eliminated as unworthy of training. This may seem harsh, but it is hardly arbitrary; the urgencies of the surgical patient routinely require intense personal commitment and sacrifice. This selection criterion ensures that the chosen few will obsessively pursue "whatever is necessary" to save the patient. The problem is that repeated reinforcement of such powerful images of rescue contributes to "a sense of omnipotence, impeding surgeons from admitting their limitations and failures when patients fail to get well and die."

Bosk[1] and Cassell[4] link surgeon optimism with denial of even the possibility of failure. It is hardly surprising (and, from an operative candidate's standpoint, rather reassuring!) that surgeons exude both confidence and commitment to the successful outcomes of the patient and the proposed operation. Who, after all, would choose to be operated on by an indecisive or ambivalent surgeon? So in the discussion of the proposed operation, the surgeon emphasizes the anticipated benefits, while only briefly mentioning the possible complications and even then pointing out that complication rates are very low indeed.

The surgeon's heroic optimism unfortunately predisposes to the creation of barriers to communication with his or her patient, particularly when the news is unfavorable or (worse) that the rescue attempt has failed. Katz[3] has observed that surgeons' heroic actions may prevent those surgeons from offering solutions focused on comfort as opposed to cure.

For the vast majority of patients, surgery is uncomplicated and acknowledgment is never an issue. Unfortunately, a small number of patients face life-threatening complications. These are the patients who end up in the SICU on varying degrees of life support. Addressing this setting, the Institute of Medicine recently asked:

> Are ICU staff, specialty services, and other personnel trained to recognize patients (and families) for whom

the goals of curative or life-prolonging care should be reconsidered with particular attention to the goals of physical and emotional comfort and symptom relief? Are procedures in place for arranging appropriate care and consultations? Are the important roles of nurses, social workers, and others recognized and supported?[5]

Affirmative answers to these crucial questions may be beside the point in the SICU if the responsible surgeon cannot or will not acknowledge that the rescue attempt is failing.

CARE AND COMFORT IN THE ICU: ROLES OF CRITICAL CARE NURSES

Critical care units are a relatively recent phenomenon. Such units could not have developed without a host of technologic advances in life support equipment. The actual units were generated in response to epidemics that required widespread use of this technology.[6] A dramatic example is the worldwide poliomyelitis epidemic of the 1950s. During this epidemic, many young, previously healthy patients stricken with polio required mechanical ventilatory support to avoid death from acute respiratory failure.[7] Nurses were specially trained to deliver such intensive care.

To attain technologic competence, critical care nurses must "use discretion in care, independent judgment, communication, and technical skills, and . . . communicate frequently with physicians."[6] Indeed, such communication is so integral to patient management in critical care units that both the American Association of Critical Care Nurses and the Society of Critical Care Medicine have incorporated into their mission statements assertions that professional collaboration is essential to critical care practice.

As the clinicians most present at the bedside, nurses in the critical care environment spend much more time communicating with patients and their family members than do other members of the healthcare team.[8-10] Professionally grounded in the belief that establishing and maintaining effective channels of therapeutic communication is requisite to basic nursing practice, critical care nurses frequently relay information to, and among, patients, families, and physicians. The information channels are complex. Many times, families, experiencing the crisis of having a relative critically ill, need information repeated or framed in a different way.[11] In addition, phy-

sicians frequently rely on nurses to ensure that timing is optimal for giving the family updates on a patient's condition. Jezewski[12] suggested that critical care nurses are "culture brokers," bridging the complex cultural environment of the critical care unit between the physicians, patients, and families.

There are few situations more complex than determining when a patient's death is inevitable. Baggs and Schmitt[13] observed that critical care nurses and resident physicians working in critical care expressed similar philosophies about the levels of aggressiveness of care that should be pursued in hypothetical clinical situations. This supports the notion that resident physicians and nurses in the critical care environment tend to agree about general management decisions. A recent survey of critical care physicians and nurses found little specific agreement about withdrawal of life support when these clinicians were challenged with the same hypothetical case scenarios.[14] Not only was there little agreement between physicians and nurses, but also among professional peers.

Faced with the complexity of end-of-life decisions, collaborative professional relationships are challenged. As the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) demonstrates, physicians have difficulty listening to nurses unless the nurse is responding to a physician-posed question.[15,16] Although physicians in the critical care setting believe that their practice relationship with nurses is collaborative and value the information relayed to them by nurses, they typically do not involve them in end-of-life decision making.[8,17,18] So, nurse-initiated attempts to share knowledge of patient and family desires in the context of end-of-life decision making may go unheard. One study that compared physician-nurse relationships in both medical ICUs and SICUs found that although surgical attending intensivists reported higher levels of physician-nurse collaboration than did medical intensivists, SICU nurses reported lower levels of collaboration than did the nurses in medical ICUs.[19] The absence of collaboration leads to a perception of powerlessness in the face of ethical dilemmas, leading nurses to describe themselves as ineffective. The consequences include frustration and professional exhaustion. The response of individual nurses is often to withdraw from the challenges of ethical decision making, creating a vicious circle. Only a brave few continue to involve themselves in the ethical aspects of SICU care, especially end-of-life

care.[20] Although these findings may not be generally applicable to all SICU settings, these results suggest a dissonance between physicians and nurses in the SICU when difficult decisions are made, including the determination that a patient is terminally ill.

When critical care nurses believe that a patient's demise is evident, they tend to reformulate their priorities. The collaborative goals focusing on recovery change to ensuring a peaceful death.[21] Nurses feel frustrated when they believe that death is inevitable, and either the patient's family is in denial or the physician does not agree that the patient's condition is terminal.[22] Asch and colleagues[8] note that when the end of life is imminent, the nurse's role is "between" the family and physician as the "information giver." These researchers also assert that critical care nurses feel immense frustration about the seeming lack of consensus concerning end-of-life care and that critical care units do not deliver the compassionate care that patients and their families need during these trying times. On the other hand, Simpson[21] asserts that when the family, physician, and nurse share the belief that the patient's death is inevitable, the nurse derives much satisfaction with "reconnecting" the family through facilitating discussion of the death and encouraging more family visitation with the terminally ill patient. This process of "reconnection" is viewed by critical care nurses as important in ensuring that hopelessly ill patients experience a "peaceful death."

Critical care nurses serve as "culture brokers." When patient, family, and caregivers share common perceptions and goals, this particular role is often simplified to that of translator, ensuring that communication is timely, accurate, and consistent. In contrast, when the perceptions and goals are dissonant, the brokerage role often requires nurses to assume additional responsibilities of arbitration and diplomacy. When surgeons fail to acknowledge that the rescue attempt is faltering, the critical care nurse cannot succeed as culture broker. A common consequence is that the therapeutic alliance among surgeon, nurse, patient, and family frequently unravels near the end of the patient's life. We focus on the idea of accountability for the imminent death.

ACCOUNTABILITY AND ERROR

Casarett and colleagues[23] reported that physician decisions to override a do-not-resuscitate order depend, at least in part, on whether the death is perceived to be iatrogenic. These workers used vignette methodology to

examine the beliefs of 358 physicians of diverse training and seniority. Briefly, each was presented with three vignettes portraying similarly terminal situations and differing only with respect to the circumstances precipitating a cardiac arrest: a medication prescribing error; an unanticipated anaphylactic response to an indicated medication; and progression of underlying disease. The data show that physicians would follow a DNR directive when the cardiac arrest was the result of underlying disease, but they would violate the directive and vigorously resuscitate when the arrest followed an unforeseeable complication or iatrogenic error. Three explanations for the differing behavior were proposed: fear of litigation; sense that the patient did not consider iatrogenic error when executing the advance directive; and the physician's sense of accountability for the death. Physicians place significant personal moral and psychologic weight on error despite recommendations that adverse outcomes be viewed as system failures, not individual fault. Although experts have suggested that errors should not alter ethical obligations to respect patients' right to refuse particular treatments, it appears that "physicians perceive an obligation to correct errors when they occur and believe that their obligation to correct error outweighs the ethical duty to respect patients' refusal of treatments." No medical specialist senses this obligation to correct error more strongly than the surgeon whose postoperative patient is in trouble.

TEMPERAMENT OF THE SURGEON

Surgeons perceive themselves as warriors, who "take up the scalpel against disease [and] resist with force its invasion on the body.[24,25,26] Traditionally masculine death-haunted occupations, such as surgeon, soldier, test pilot, firefighter, and race car driver, focus on one pole of a set of cultural oppositions: practitioners describe themselves and their comrades as active, strong, decisive, brave, aggressive.[27] These men take the metaphor of war literally: from the "front lines" or "trenches" they carry out "blind maneuvers," attack "invading tumors," and conduct "search and destroy" missions.[28,29]

Although surgeons cherish the image of the hero engaged in single-handed combat with death and disease,[30,31] the war is, in fact, waged by a team. Like the army, the structure is hierarchical, with a commander who not only directs the combat, but also explicitly accepts responsibility for the outcomes. Surgeons celebrate their judgment in life and death matters ("often right,

rarely wrong, never in doubt"), pride themselves in their "total care of the patient," and hold themselves accountable for the outcomes of that care. So the surgeon wages his or her war against the forces of bodily destruction on many battlefields. Nurses on the surgical "floor," radiologists, medical specialists, and intensivists are all mobilized when necessary. The surgeon determines the strategy, makes the final decisions, and, like a general, bears responsibility for the consequences. Not surprisingly, "leadership ability" (including accountability for global outcomes) is one of the qualities chiefs of surgery seek in prospective residents.[32]

"A chance to cut is a chance to cure" is a surgical aphorism that is, in fact, serious despite its ironic pose. The mocking adage, "No patient should be denied the benefits of surgery based on diagnosis alone" describes an opinion frequently found among surgeons. There is a powerful, if anecdotal, basis for this position: every surgeon has observed patients, who, by all objective evidence, are dying, "miraculously cured" after being operated on.

THE COVENANT AND THE MIRACLE

Despite the intrusion of contractual relationships into modern medicine (HMOs manage "obligations" between providers and clients), surgeons hold fast to the covenantal relationship between patient and physician.[33,34] The surgeon is not hired to perform a technical service. The surgeon who does just this is described mockingly by peers as "cut here." The surgeon enters into a relationship with the patient (and, by extension, the family) that commits the surgeon to curing the disease. The covenant includes shared hope, shared risk, and mutual respect. As Cassell points out, the covenant is made with a person, family, or both. The technical aspects of the operation, performed while the patient is anonymized by drapes, supports the covenant but does not fulfill it.

Both surgeons and patients speak of surgical miracles. Although this is a metaphor, and a wish, a successful operation does share some characteristics with miracles. (1) A miracle is rapid, it does not unfold, it occurs; medical care is generally a process extending over time, surgery occurs in a measurable, sharply delimited period of time. (2) A miracle is spectacular, consisting of a reversal or transformation; it propels a person or substance from a disvalued to a valued state: sickness to health, death to life, water to wine. (3) It is definitive; the ben-

eficiary was sick, is well; disease was excised; the patient is cured. (4) A miracle is attributable; everyone knows who was responsible. (5) It is performed by someone with extraordinary powers; specialized knowledge and training, access to marvelous substances, or a relation to mystical or supernatural forces may be cited to explain these powers. (6) A miracle is unpredictable and mysterious: although it may be involved with rationality, in some ways, it transcends known, natural forces; it inspires hope, fear, wonder.

A kind of gambler's calculus determines the dimensions of the surgical miracle, tallying the chance of a favorable outcome and what is being wagered. Most of these miracles are relatively routine, with a high probability of success and comparatively little risked in case of failure. For patients, of course, few procedures are routine; the odds are more familiar to surgeons than patients. Statistical odds cannot predict the outcomes of today's encounter between this particular patient and this surgeon in this operating room. An element of uncertainty, of mystery, abides. Operations that triumph over desperate odds and life-threatening risks delight surgeons, who replay the details to colleagues and flaunt their victories at surgical "grand rounds."[35] The victory is perceived as theirs more than their patient's.

Although the term *miracle* is a metaphor, it binds surgeons and patients together. Both long for "miraculous" cures. Both believe in their possibility, and hope against hope that, when the odds are adverse, a surgical "miracle" will be wrought. Such is the nature of the surgeon-patient covenant. The temperament of surgeons—daring, arrogant, egotistical, activist[36]—and the culture of surgery reinforce these vain and, on occasion, dangerous hopes.

TEMPERAMENT OF THE SURGEON: OBSERVATIONS AND EFFECTS

The aggressive, decisive, and confident temperament is both sought and developed. It is first assessed when department leaders interview prospective residents; those who seem indecisive or lacking in self-confidence are bypassed.[37] Indeed, senior surgeons look forward to working with chief residents who take charge of the service, as opposed to letting the service run them.

Such leadership opportunity comes at great cost to the trainee. Bosk[1] quoted a senior surgeon who summarized the training of surgeons as "a funny business. You force strong-willed, aggressive, intelligent individuals to be-

come peons. The goal is by having these individuals sublimate all their own independence, they will come out five years later as strong individuals with confidence in their own skills, judgment, and ability."[38] Indeed, surgical trainees have described their training as 5 years of continuous scrutiny during which their errors are painfully—and shamefully—exposed to their peers and superiors. Their subordinate position is repeatedly emphasized throughout the training process. Caustic, often public, rejoinders that aim to shame (eg, "Are you stupid or is it that you just don't care?" "Why don't you just throw the patient down the elevator shaft? You'd kill him quicker and it would be less painful for all concerned.") are traditionally used to highlight departures from expected care and to discourage others from trying the same. As Talmudic sages observed, shaming another in public is like shedding blood[39] and the consequent humiliation is worse than physical pain.[40]

Yet the message is decidedly mixed. Among senior surgeons, daring "saves" are admired. Surgeons who are excessively cautious are derided by colleagues[41] while those who perform aggressively heroic surgery on patients who might not tolerate the stress of an operation are labeled "matadors" or "gunslingers"—terms that express a certain covert admiration and heroic ideal.[42]

The dichotomy is systematized into the domains of unexpected success and unexpected failure,[43] the unexpected event triggering a specific surgical ritual. Extraordinary successes are celebrated in the Grand Rounds ritual, where a surgeon initially describes a heroic "save," often accomplished against all odds, and then follows the presentation of the case with an erudite discussion of his or her approach to diagnosis and management. Unexpected deaths and complications are presented at the pivotal M and M conference.[44,45] Senior surgeons responsible for unexpected deaths or complications "publicly abase themselves before an audience of their colleagues and subordinates." They publicly claim that they made mistakes in the handling of the case. "They put on the hair shirt, as the argot of surgery has it."[46]

These public ritualized admissions of fallibility, says Bosk, substitute for the public sanctioning of senior surgeons. With such admissions, senior surgeons take responsibility not only for their own mistakes in judgment, but also for those made by subordinates. Senior surgeons' public admissions of accountability for all that happens to their patient dramatize proper moral behavior: full and open disclosure and complete intellectual

integrity. "By this practice, surgeons excuse their mistakes by admitting them."[47] They admit to technical errors, and errors of judgment, but demonstrate that they are morally above reproach. Technical and judgmental errors might occur, even to the celebrated surgeons at the elite institution studied by Bosk; they were forgivable. Moral errors were considered unforgivable. Of all the moral ("normative" in Bosk's terms) errors, the most egregious involved abandoning the patient in time of need and failing to hold oneself accountable for patient outcomes.

The central point is that for those of surgical temperament, expected successes and expected failures are no-confusion events; an unexpected success is publicly dramatized and admired by colleagues and subordinates. These are precisely the "miracles" that demonstrate the heroism of the surgeon who, like the medieval knight of legend, has jousted with death and won. Small wonder that surgeons often attempt to snatch victory from the jaws of defeat: however poor the odds, this one time might be the time to turn expected failure into unexpected success. Failure culminating in death are much more likely to be classified as "expected" if the surgeon has "done everything." To make a "half-hearted attempt" to save a patient risks the death being labeled the consequence of the surgeon's normative (moral) error.

As Benner and colleagues[10] point out, therapeutic interventions have become a symbolic language of caring for and valuing the patient's life. Explanations about progress, decisions, and options at the end of life are often delivered by the surgeon in a biomedical context (eg, "He is not responding to the blood pressure medication"), but are necessarily interpreted by the family in a "life-world" context (eg, "He is not going to come home to us"). There is already strong evidence that the critical care nurse routinely and necessarily intervenes on the family's behalf to facilitate the translation. We hypothesize that the surgeon's substitution of interventions as symbols for caring, the need to be seen to have "done everything," may be rooted in the effect of shame.

THE TEMPERAMENT OF THE SURGEON: A WORKING HYPOTHESIS CONCERNING ITS ORIGIN

Why do surgeons choose to publicly celebrate their unexpected successes yet often find comparatively little satisfaction in the ordinary success? Why do surgeons insist on public (peer) confession of unexpected failures but do not focus on the needs of the patient and family when faced with the more common expected failure? Why do surgeons ritualize group reinforcement of their individual successes? Why do surgeons ritualize individual confession of guilt for poor outcomes to their peer group?

One possibility revolves around what Wurmser[48] calls "inner shame." It is the response to being perceived as weak or failing. It is universally experienced and often serves as the fuel for extraordinary achievements in domains as diverse as the arts, athletics, and the sciences. The drive "to be the best" is frequently a response to the fear that one will otherwise be found wanting or, as Vince Lombardi put it, "Winning isn't everything, it's the only thing." Shame, or, more precisely, our defense against shame, obscures real weakness. Those behaviors that obscure the underlying weakness are termed by Wurmser the "masks of shame." The masks shield the "inner self." Those masks also shield the profession, the fellowship of surgeons.

The masks of shame appear to be prominent in the temperament of the surgeon. They include contempt (eg, the denigration of medical colleagues as being insignificant); an attitude of machismo perceived by nonsurgeons as obtrusive; systematic public humiliation and ridicule of others (particularly trainees, as noted previously); defiance; and perhaps most importantly, repeated attempts to heroically transcend shame through noble action. The scheduled sessions in which the surgeon's worth is externally validated by colleagues suggest that grand rounds meets a group need beyond mere education. The scheduled sessions in which ritualized confession and external humiliation are expected are of substantial importance in improving patient care. But these same sessions also shield the profession's members from deeper feelings of unworthiness linked to their (patients') complications. More simply, the expression of accountability for the complication (guilt for the external event) neutralizes, to a greater or lesser degree, doubts concerning one's ability as a surgeon and the inner shame of being found imperfect.

Is shame necessary to the art of surgery? If surgical care were founded entirely on evidence-based, rational thought and could be entirely represented as the application of cognitive and technical skills, shame might be superfluous. Train hard enough, and perfection is possible. The reality is that surgical care is a blend of knowledge and hunches, algorithms and insight, duplication and creativity. Wurmser's reasoning suggests that shame

is necessary to protect the hunches, the insight, and the creativity that define surgeons and their profession. The rescue imperative requires surgeons to calculate the odds, and then ignore them: in *this* case, for *my* patient, the odds do not apply. Shame is more than an adaptive response. It is fundamental to surgeons and surgical care.

This is a working hypothesis, not a statement of fact. The masks of shame may or may not underlie the surgical temperament. But if this hypothesis is even partially correct, it suggests that the surgeon may perceive the impending death of his or her patient quite differently from the patient, family, and other caregivers. For the heroic surgeon, that death may well reveal to the world that he, the surgeon, is "not good enough," unworthy, and so on. In this construct, the surgeon's denial of advance directives, the reluctance to change the focus of therapy from "cure" to "comfort care," and the use of interventions as symbolic for caring meet instinctive needs of the surgeon quite apart from the needs of others involved in the process of dying. There is little information on the perception of the role of the surgeon by the surviving family and friends of a patient who has died.

Gender differences lend some credence to this working hypothesis. There is presently a small population of women surgeons. When Cassell began studying those women surgeons in the 1990s, she began her research with the impression that aggressively heroic behaviors were less common among women. This impression was refuted by the research: women surgeons are similarly aggressive in their patient advocacy. The heroics of heroes are nevertheless different from the heroics of heroines. Women appear to be socialized to be more sensitive to feelings of patients, family members, and nurses. In particular, they appear much more concerned than their male colleagues with not causing unnecessary suffering. Although daring, arrogant, egotistical women surgeons surely exist, such characteristics go against the cultural grain.

Heroines in America, including surgical heroines, are more prone to self-sacrifice than their male counterparts, and the balance between the pain of inner shame and the guilt associated with causing others to suffer may not be quite so lopsided. This is important not only because it highlights cultural, gender-based differences in behavior that feed into training but also because the proportion of women obtaining surgical training is rising rapidly. Caring for the social person is rising in pro-fessional value (compared with curing the physiologic person).

Other emotions such as guilt, regret, frustration, and anger are often observed and may even play a significant role in day-to-day conduct of the SICU. Yet the choice of shame as a driving force has deeper logic. As Lewis[49] observed, the thread of shame is so deeply woven into human contact and discourse that it is easily overlooked. Lazare[50] points out that even ordinary clinical contact is likely to generate reciprocal shame among provider and patient, emphasizing that "one of the most difficult but important tasks for physicians in the clinical encounter is the recognition and management of their own shame." What is remarkable is not that physicians must manage their own shame, but rather that "the subject of shame . . . in the medical care of patients . . . is seldom discussed, studied, or written about."

THE SICU DILEMMA

Surgeons and their patients greatly value their covenantal relationship: "Trust in me, and I will care for you." Correction of anatomic and physiologic defects is the means by which the surgeon fulfills the covenant. Provided that the patient improves as its consequence, the operation is sufficient to fulfill the covenant.

An attempt to rescue the physiologically deteriorating patient is part of the covenant, with the SICU serving as the common venue. We suggest that the surgeon is ideally trained to organize and sustain the rescue attempt. We suggest that the surgeon is poorly positioned to abort the rescue attempt when it has failed. The covenant between the surgeon and the patient as social and, at the end of life, spiritual beings demands comfort and dignity. Repeated fruitless attempts at physiologic rescue delay and even deny these covenantal obligations.

How surgeons and their patients define the appropriate criteria to shift from attempts to cure to acceptance of death with comfort and dignity is beyond the scope of this article. We have a preliminary impression that the surgeon's interpretation of the covenant, and the surgeon's reluctance or willingness to shift from cure to comfort care, varies with the length of time the surgeon has known the patient and the surgeon's perception of accountability for the failed rescue. So surgeons who operate on trauma patients—patients who arrive injured and whom surgeons have not met beforehand—appear to be at one end of a continuum. At the opposite end are transplant surgeons who may have known the patients

and their families for years before the transplantation. These observations and impressions merit further study.

For all patients, the criteria must be defined and, more importantly, respected. The SICU dilemma arises because some surgeons are not prepared to define and to respect those criteria. Comments that "this is not what [the patient] wanted" are ignored and pleas to follow advance directives often go unheeded.

The SICU dilemma, then, is who should manage the dying patient? And what criteria should we use to decide that someone is dying?[51]

Appendix
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REFERENCES
1. Bosk CL. Forgive and remember: Managing medical failure. Chicago: University of Chicago Press; 1979.
2. Nuland S. How we die. New York: Knopf; 1993:250–253.
3. Katz P. The scalpel's edge: The culture of surgeons. Needham Heights, MA: Allyn and Bacon; 1999.
4. Cassell J. Expected miracles: Surgeons at work. Philadelphia: Temple University Press; 1992.
5. Field MJ, Cassel CK, eds. Approaching death: Improving care at the end of life. Chapter 4. Washington, DC: Institute of Medicine, National Academy Press; 1997.
6. Baggs JG. Intensive care unit use and collaboration between nurses and physicians. Heart and Lung 1989;18:332–338.
7. Severinghaus JW, Astrup P, Murray JF. Blood gas analysis and critical care medicine. Am J Respir Crit Care Med 1998;157:S114–S122.
8. Asch DA, Shea JA, Jedrziewski MK, Bosk CL. The limits of suffering: critical care nurses' views of hospital care at the end of life. Soc Sci Med 1997;45:1661–1668.
9. Baggs JG, Ryan SA, Phelps CE, et al. The association between interdisciplinary collaboration and patient outcomes in a medical intensive care unit. Heart Lung 1992;21:18–24.
10. Benner P. Facing death: End-of-life care and decision making. In: Benner P, Hooper-Kyriakidis P, Stannard P, eds. Clinical wisdom and interventions in critical care. Philadelphia: WB Saunders; 1999.
11. Jezewski MA, Scherer Y, Miller C, Battista E. Consenting to DNR: critical care nurses' interactions with patients and family members. Am J Crit Care 1993;2:302–309.
12. Jezewski MA. Do-not-resuscitate status: conflict and culture brokering in critical care units. Heart Lung 1994;23:458–465.
13. Baggs JG, Schmitt MH. Intensive care decisions about level of aggressiveness of care. Res Nurs Health 1995;18:345–355.
14. Walter SD, Cook DJ, Guyatt GH, et al. Confidence in life-support decisions in the intensive care unit: a survey of health-care workers. Crit Care Med, 1998;26:44–49.
15. Hiltunen EF, Puopolo AL, Marks GK, et al. The nurse's role in end-of-life treatment discussions: preliminary report from the SUPPORT Project. J Cardiovasc Nurs 1995;9:68–77.
16. Covinsky KE, Fuller JD, Yaffe K, et al. Communication and decision-making in seriously ill patients: findings of the SUPPORT project. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments. J Am Geriatr Soc 2000;48:S187–193.
17. King ML, Lee JL. Perceptions of collaborative practice between Navy nurses and physicians in the ICU setting. Am J Crit Care 1994;3:331–336.
18. Bucknall T, Thomas S. Nurses' reflections on problems associated with decision-making in critical care settings. J Adv Nurs 1997;25:229–237.
19. Baggs JG, Schmitt MH, Mushlin Al, et al. Nurse-physician collaboration and satisfaction with the decision-making process in three critical care units. Am J Crit Care 1997;6:393–399.
20. Erlen JA, Frost B. Nurses' perception of powerlessness in influencing ethical decisions West J Nurs Res 1991;13:397–407.
21. Simpson SH. Reconnecting: the experiences of nurses caring for hopelessly ill patients in intensive care. Intensive Crit Care Nurs 1997;13:189–197.
22. Eliasson AH, Howard RS, Torrington KG, et al. Do-not-resuscitate decisions in the medical ICU: comparing physician and nurse opinions. Chest 1997;111:1106–1111.

23. Casarett DJ, Stocking CB, Siegler M. Would physicians override a do-not-resuscitate order when a cardiac arrest is iatrogenic? J Gen Intern Med 1999;14:35–38.

24. Bosk CL. Forgive and remember: Managing medical failure. Chicago: University of Chicago Press; 1979:90.

25. Schwartzbart G. The romantic aspects of being a surgeon. Medical News 22, 1982.

26. Selzer R. Mortal lessons: Notes on the art of surgery. New York: Simon & Schuster; 1974:40–41.

27. Cassell J. The woman in the surgeon's body. Cambridge MA: Harvard University Press; 1998.

28. Cassell J. Expected miracles: Surgeons at work. Philadelphia: Temple University Press; 1992:33–59.

29. Cassell J. The woman in the surgeon's body. Cambridge MA: Harvard University Press; 1998:17–20.

30. Selzer R. Letters to a young doctor. New York: Simon & Schuster; 1982:114–115.

31. Cassell J. Expected miracles: Surgeons at work. Philadelphia: Temple University Press; 1992:30, 42.

32. Cassell J. Expected miracles: Surgeons at work. Philadelphia: Temple University Press; 1992:40–41.

33. May WF. Testing the medical covenant: Active euthanasia and health care reform. Grand Rapids MI: William B Eerdmans Publishing Company; 1996:367–369.

34. Cassell J. Perturbing the system: "Hard science" "soft science" and social science. Human Organization, in press.

35. Cassell J. Expected miracles: Surgeons at work. Philadelphia: Temple University Press; 1992:3–4.

36. Cassell J. The good surgeon. Int J Moral Soc Studies 1987;2: 155–171.

37. Cassell J. Of control, certitude, and the 'paranoia' of surgeons. Cult Med Psychiatry 1987;11:229–249.

38. Bosk CL. Forgive and remember: Managing medical failure. Chicago: University of Chicago Press; 1979:67.

39. Talmud, Baba Metzia 59a.

40. Talmud, Sota 10a.

41. Cassell J. Dismembering the image of God: Surgeons, wimps, heroes and miracles. Anthropol Today 1986;2:13–16.

42. Bosk CL. Forgive and remember: Managing medical failure. Chicago: University of Chicago Press; 1979:50–51.

43. Bosk CL. Forgive and remember: Managing medical failure. Chicago: University of Chicago Press; 1979:116–146.

44. Bosk CL. Forgive and remember: Managing medical failure. Chicago: University of Chicago Press; 1979:127–146.

45. Cassell J. Expected miracles: Surgeons at work. Philadelphia: Temple University Press; 1992:134–137.

46. Bosk CL. Forgive and remember: Managing medical failure. Chicago: University of Chicago Press; 1979:137–138.

47. Bosk CL. Forgive and remember: Managing medical failure. Chicago: University of Chicago Press; 1979:145.

48. Wurmser L. The mask of shame. London: Aronson; 1997.

49. Lewis HB. Shame and guilt in neurosis. New York: International Universities Press; 1971.

50. Lazare A. Shame, humiliation and stigma in the medical interview. In: Lansky MR, Morrison AP, eds. The widening scope of shame. Hillsdale, NJ: Analytic Press; 1997:383.

51. Rubenfeld GD, Curtis JR. End-of-life care in the intensive care unit: a research agenda. Crit Care Med 2001; 29:2001–2006.