

## "It Blew My Mind"

### Exploring the Difficulties of Anesthesia Informed Consent through Narrative

THE article by Waisel *et al.*<sup>1</sup> in this issue of ANESTHESIOLOGY is packed with compelling narratives and evokes both our own experiences and other tales. In one such tale, chronicled in *Hold Your Breath*—a documentary film by Maren Grainger-Monsen about an elderly Afghani man with advanced stomach cancer—an informed consent misunderstanding results in a heart-rending moment.\* Mr. Kochi is filmed during multiple clinic visits with his compassionate, highly skilled oncologist. At each visit we "hear," through an interpreter, the patient refuse chemotherapy. But it is not until well into the film that we learn the patient misunderstood his treatment options. He had refused chemotherapy because it was offered as a continuous infusion, a method which would interfere with his religious requirements to be "clean" five times a day for prayer. Not until one of his daughters, feisty and completely bilingual, attends an office visit, does it become clear to all that he would have consented to any other form of chemotherapy. It is a moment which elicits anger, frustration, and bewilderment on screen. Within, meanwhile, we feel the pang of empathic concern—the pang that reminds us that we are all human in this endeavor called medicine.

Anesthesiology, in so many ways, is crystallized medical care. We rarely, if ever, have the luxury of multiple office visits to connect with the patient and family. Hence, if informed consent difficulties occur in the setting of repeated, relatively lengthy visits, how many tribulations must arise in the time-crunch arena where the patient meets an anesthesiologist and must trust (to some degree) this stranger with his or her life?

Thus the article by Waisel *et al.* is welcome indeed. For not only does the study offer us the pangs of acknowledgment of human-human encounters as we read the narratives, but it also brings to the fore the fact that the practice of anesthesiology can be stressful—even without a drop in oxygen saturation or rise in ST segments.<sup>2</sup>

This Editorial View accompanies the following article: Waisel DB, Lamiani G, Sandrock NJ, Pascucci R, Truog RD, Meyer EC: Anesthesiology trainees face ethical, practical, and relational challenges in obtaining informed consent. ANESTHESIOLOGY 2009; 110:480-6.

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\* *Hold Your Breath*. Available at <http://medethicsfilms.stanford.edu/>. Accessed August 24, 2008.

In the study, narratives were generated from resident and fellow trainees scheduled to attend an education program on relational and communication skills specifically designed for the anesthesiologist. Trainees were given the following writing prompt: "Write about an informed consent experience with a patient/family that you found particularly challenging." This is remarkable for several reasons.

First, time in the training program was devoted to enhancing a skill set which does not include airway management, drug dosing, regional needle placement, or monitoring technique. Despite early editorial commentary which devalued the use of anesthesia simulators for relational skill development,<sup>3</sup> the recognition and promotion of such skills, attitudes, and knowledge stem in part from the research and educational efforts of those involved in simulation-based anesthesia training. Frequently termed nontechnical skills, teamwork, leadership, and communication skills are embedded and discussed in simulator training and debriefing.<sup>4</sup> In the highly dynamic setting of an operating suite or intensive care unit bay, interpersonal skills are central to good patient care.

Second, anesthesia trainees were asked to write. The writing gave residents and fellows a voice in their own training. In being asked to write and using the writings as cases for educational sessions, the teachers were already teaching and conveying key messages to the learners even before any of the sessions began: what you have to say is valuable; what you have to say is unique to you but of interest to others; what you have to say cannot be captured by markings on a multiple choice test; and, perhaps most importantly, there is no single right answer for much of what we do. Interactions between people are complex, multilayered, often ambiguous, and sometimes frustrating. Narrative medicine emerged from the medical humanities field of literature and medicine as an academic discipline that explores the relationships between careful analysis of text and doctoring.<sup>5</sup> The use of writing by doctors and doctors-in-training can be viewed as a tool which promotes reflection; in the setting of a classroom or other group, it promotes community, a deeper presentation of self, and an acknowledgment of vulnerability, fallibility, and other human traits frequently squelched by the press of expectations for perfection in medicine.<sup>6</sup>

Third, the study acknowledges a wide, inclusive definition of medical ethics. Rather than left to wander lost and stuporous in a miasma of ethics terminology and systems (autonomy! virtue-ethics! casuistry! deontol-

ogy!), trainees were instead encouraged to write about their own experience with a challenging informed consent interaction. Although the facilitator can, in the discussion or classroom setting, define relevant terms, such as decision-making capacity, the terms themselves do not delineate the sum total of the learning. This is particularly important in areas of conflicting values, goals, and perceptions. As Tolstoy has famously written about families—"All happy families are alike; each unhappy family is unhappy in its own way"<sup>7</sup>—so can it also be said of human interactions in general and informed consent discussions in particular: each unhappy encounter is unhappy in its own way. Parsing the singularities of a situation and revealing the underlying themes that connect various scenarios and stories is the work of medical humanities and narrative research.

For the past dozen years, the anesthesia training program at Stanford has included sessions called "Ethics in the OR." Although placed in the didactic lecture series, the sessions are run as case-based discussions. Using a broad definition of an ethical problem adapted from Chambers,<sup>8</sup> we ask residents to submit brief narratives of incidents that "troubled or bothered" the resident. A number of submissions have involved informed consent, frequently in concert with other issues such as production pressure, end-of-life, pediatric assent, etc. Sessions are accompanied by handouts with resources and references relevant to ethics and anesthesia, both generally and as related to the cases to be discussed. The discussions are lively, generative, and at times impassioned.

The power of these experiences to elicit emotion in the anesthesiologist is central to the value of writing about the experience. Phrases such as "it blew my mind," "my attempts to reason with him were futile," "dilemma," "I kept digging myself deeper and deeper," "a painful discussion," "I felt bad," "I felt very uncomfortable," and "disturbed" reflect recall of potent emotional experiences in the study by Waisel *et al.* Some trainees perceived patients to be "belligerent," "very irritated," and "angry." We enter patients' and families'

lives at critical junctures—the emotional import of the moment can be intense. Furthermore, we remember and mull over unsatisfactory interactions; this study demonstrates a way to effectively use such experiences. Emotion is intrinsically related to memory and learning, an interaction used in simulation-based education.<sup>9</sup> Writing about emotion-laden events has been shown to be beneficial, even without other interventions.<sup>10</sup>

The fact that these trainees are cognizant of the difficulties of obtaining informed consent bodes well for our specialty. Research and education about such difficulties as exemplified in the current study are important reminders that anesthesiologists are not mere technical experts. Rather, our lives and livelihoods are inextricably intertwined. Our memories, frustrations, triumphs, hopes, aversions and affections are not to be denied and ignored, but rather acknowledged as part of us. Writing and sharing our stories of challenging incidents are activities useful not only for us, but also for the care of our future patients.

**Audrey Shafer, M.D.,** Department of Anesthesia, Stanford University School of Medicine, and Veterans Affairs Palo Alto Health Care System, Palo Alto, California. [ashafer@stanford.edu](mailto:ashafer@stanford.edu)

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