

Seeking Consent for Cardiac Surgery

Mr. Kors had been noticing persistent shortness of breath during his daily walks, but he attributed it to simply getting older now that he had entered his 70's. However, when he began experiencing chest tightness and fatigue even while resting, Mr. Kors decided to schedule an appointment with his physician. After an echocardiogram and stress test, Mr. Kors is told that he has severe aortic stenosis which involves a narrowing of the heart's aortic valve, restricting blood flow to the heart and causing his heart to work harder when pumping blood. Because this news was quite unexpected, Mr. Kors quickly felt overwhelmed and anxious about the diagnosis, but his physician assured him that treatment options were available and referred him to Dr. Saliba, a highly regarded cardiac surgeon, to discuss a valve replacement.

Three weeks later, Mr. Kors arrived at Dr. Saliba's cardiology practice. Over the past twenty five years, Dr. Saliba has built an impressive reputation performing traditional open-heart surgical aortic valve replacement (SAVR), with complication rates well below the national average. Recently, Dr. Saliba has also begun offering a transcatheter aortic valve replacement (TAVR) to eligible patients like Mr. Kors. During their consultation, Dr. Saliba explains that SAVR involves opening the chest cavity in order to access the heart directly and replacing the damaged valve, while TAVR is a less invasive procedure in which a catheter is threaded through a blood vessel in order to deliver and implant the new valve without opening the chest.

Dr. Saliba readily acknowledges that his experience with TAVR is not nearly as extensive, given that he's only performed a dozen procedures using TAVR over the past six months. However, he also tells Mr. Kors that "TAVR represents the future direction of valve replacement therapy. By avoiding the need to open the chest cavity, it can further lower complication rates while being equally effective for valve replacements. This makes it superior for patients who are immunocompromised or who could have difficulty recovering from major surgery."

Another potential option would be a Ross procedure, in which the patient's own pulmonary valve is moved to replace the damaged aortic valve, and a donor valve replaces the pulmonary valve. This more complex surgery is typically reserved for younger patients or those with specific anatomical considerations. After reviewing Mr. Kors' imaging studies and medical history, Dr. Saliba determines that Mr. Kors' age and overall health profile make him a better candidate for either SAVR or TAVR. Because of this assessment, Dr. Saliba decides not to discuss the Ross procedure with Mr. Kors during their meeting.

Dr. Saliba has also recently read several studies indicating that for patients with Mr. Kors' risk profile and symptom severity, medical management with careful monitoring can sometimes delay

the need for valve replacement by several months or even years. However, as a surgeon, Dr. Saliba has limited experience following patients who opt for conservative medical management rather than proceeding with valve replacement. Given his surgical expertise and concerns about disease progression, he doesn't feel he can adequately counsel Mr. Kors on this approach. Furthermore, given the relatively low risk profile of both surgical options available, Dr. Saliba believes it's prudent to address the problem definitively rather than wait. For these reasons, Dr. Saliba also does not mention the possibility of trying medical management alone.

When presenting SAVR as an option, Dr. Saliba begins by explaining that the expected benefits are to protect Mr. Kors' heart and increase blood flow by replacing his aortic valve, ultimately helping to extend Mr. Kors' life and relieve his symptoms. He explains that the procedure requires Mr. Kors to be put under anesthesia, connected to a heart-lung machine, and then a six-inch vertical cut will be made along his sternum in order to access his heart. After replacing the aortic valve and removing the damaged valve, his breastbone will be wired back together and the incision site will be closed. He tells Mr. Kors that the procedure takes between two to four hours. Dr. Saliba then explains that the risks associated with open-heart surgery include infection, bleeding, blood clots/stroke, triggering a heart attack or an abnormal heart rhythm, chest pain, fatigue, and in some cases death. However, he also emphasizes his particularly strong track record with this procedure and shares specific success rates from his own practice. He also discusses the recovery timeline for the procedure.

When presenting TAVR as an option, Dr. Saliba begins by explaining that the expected benefits are the same as SAVR, with the main difference being the surgical approach for replacing the valve. Both procedures involve anesthesia, but instead of making a long incision across Mr. Kors' chest, a small incision would be made on his upper thigh in order to access the femoral artery. A small tube called a catheter would then be threaded up the artery toward his heart, and then a new valve will be placed, pushing the damaged valve out of the way. The catheter is then removed and the small incision site closed. He tells Mr. Kors that the procedure takes only one to two hours. When discussing the risks associated with TAVR, Dr. Saliba notes that types of surgical risks are the same as for SAVR, but because TAVR is much faster and the incision is significantly smaller, the risks are greatly minimized as compared to SAVR. He says that the recovery time is also much faster, often taking only a few days rather than several weeks.

However, Dr. Saliba also reminds Mr. Kors that although the risks of TAVR are less significant in theory, he also has less experience with the new minimally invasive catheter-based procedure and a long history of very good outcomes with the traditional SAVR procedure. Dr. Saliba ends the appointment by telling Mr. Kors that while he recommends proceeding with valve replacement, the choice between consenting to the SAVR or TAVR is up to Mr. Kors, and that he also does not need to consent to either procedure if he's uncomfortable with getting surgery, in which case Mr. Kors would be referred back to his cardiologist for further discussions about non-surgical options.

After hearing about both the traditional open-heart surgery and the minimally invasive catheter-based procedure, Mr. Kors feels unprepared to make such a significant decision. Despite having had three weeks since his initial diagnosis, Mr. Kors remains shaken by the news that his heart requires major intervention. He also finds that his anxiety makes it hard to fully absorb all the technical medical information Dr. Saliba has shared. Mr. Kors does his best to follow the explanations and asks for clarification when details seem unclear, but he admits that he simply doesn't know how to properly decide between the options. After all, he spent his career as an investment banker, not a physician, and has no background in cardiac medicine.

Mr. Kors knows his daughter is deeply concerned about his condition and wants him to choose whatever treatment offers the best chance of recovery so he can quickly return to caring for himself independently. She has agreed to take care of him while he recovers, but she will have to take time away from her own job to help him. However, Mr. Kors doesn't know if that means he should go with the less invasive procedure that his surgeon is less experienced in, or the more invasive procedure that his surgeon has an incredible track record with. Feeling overwhelmed and apprehensive about the entire situation, Mr. Kors tells Dr. Saliba that he trusts the doctor's judgment completely. He explains that he would like to proceed with whichever procedure Dr. Saliba believes is best suited for his particular case and that he will sign his consent to whichever procedure Dr. Saliba recommends.