Ethical Problems Special to Surgery

Surgical Teaching, Surgical Innovation, and the Surgeon in Managed Care

Francis D. Moore, MD

This article will concern itself with 3 ethical challenges that are special to the role of the surgeon in our society. First is the teaching of surgery. This might be called “performing an operation for the first time (for the individual surgeon).” Second is surgical innovation. This might be termed “performing a new operation for the first time ever.” The third ethical challenge is the role of the surgeon in managed care. This might be stated as “Can we trust corporations to provide all-risk coverage and freedom in clinical decisions?”

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TEACHING

“You cannot learn to play the piano by going to concerts.” This favorite quotation is a not-so-subtle reference to the fact that young surgeons must carry out operations personally and under their own responsibility to learn this wonderful clinical art and manual skill. For this important learning experience to occur without jeopardy to the patient, certain key requirements should be met.

How can a patient trust herself or himself to the care of a surgeon who “has never done it before”? It is obvious that the answer to this question lies in close supervision and participation by the more senior and experienced teacher. The American residency system of postgraduate education fosters and institutionalizes these relationships to ensure the welfare of patients in a teaching environment.

Before undertaking any crucial responsibilities in the operating room, young surgeons will have attended the work of more senior and skilled people on many occasions, usually as an assistant. They should have assisted at similar prior operations, and should have joined the teaching surgeon when he or she makes hospital rounds and sees ambulatory patients. Responsibility for the welfare of the patient naturally extends beyond the operating room, to preoperative and postoperative care and family contacts. If the teaching surgeon does not honor these responsibilities in his or her daily work, the learner is well advised to go elsewhere.

As residents acquire some of the manual facility and human felicity that are the mark of the expert, they will progress to the care of patients by doing the operation themselves. There always must be a “first time”; however, this can be made safe and without jeopardy to the patient if the supervising surgeon is present and available if needed.

What should the surgeon and the teacher say to the patient? What should the bill say?

Both teacher and pupil should tell the patient that the operation is being done by them as a team. If the supervisor has been there during the operation, the fee can rightly be assigned to the teacher, whether as an individual or through a managed-care corporation. If the teacher is paid by the corporation and the learner is a resident paid by the hospital, there need be no change in the arrangement. But if the learner is licensed to practice independently (not true of residents in most states), he or she should consider the learning experience to be the only renumeration.

Most patients who are dealt with frankly on this issue welcome the opportunity to join in the teaching of a younger generation. When it is called to their attention in an appropriate way, most members of our society, from the most afflu-
ent to the least, welcome the privilege of joining in a teaching experience.

**SURGICAL INNOVATION**

New surgical procedures come to the operating room after extensive laboratory work on the technique, anatomy, physiology, biochemistry, and pathology of the new procedure. In such instances, the performance of this operation should always be preceded by a frank statement to the patient as to what aspects are new. The patient should of course be reassured that on the basis of laboratory study—often in animal models—there is every likelihood of success.

The surgeon should be aware of the fact that patients threatened by severe illness display a surprising and sometimes alarming readiness to accept uncertainty and reach out for something new. The surgical scientist must avoid exploiting this willingness of patients to try something new in a desperate situation. It is the surgeon rather than the patient who makes the judgment of appropriateness. This judgment should not be left to the patient, who will always seek new hope and new treatment in a desperate situation, but who lacks the scientific background to make this judgment.

Sick patients and those suffering from advanced malignant neoplasms or advanced degeneration of some organ system (such as kidney failure or liver failure) will grasp at straws. They want anything on earth that might help. It is important for the innovative surgeon-scientist to avoid exploiting this universal hope of sick patients by carrying out an operation that is inadequately tested.

What makes a surgical innovation ethically acceptable? There are at least 3 aspects: laboratory background, field strength, and institutional stability.

**Laboratory Background**

The laboratory background is evident enough for new procedures being employed in teaching hospitals with ready laboratory support. But what of the case in which an innovative surgeon has no access to laboratory facilities and bases the innovation entirely on clinical experience and intuition? In either case, the surgeon should consult with someone else experienced in the field, and ask the questions, “Is this the right operation for this situation?” and “Am I the right person to be doing this operation?” It is unfortunate that we sometimes seem to rely on legal pressures for acceptability. Nonetheless, severe liability problems will beset the surgeon who attempts a new operation for the first time but who has failed to study the operation by experimental means. This is particularly true of new operations that could readily be studied in large animals. Antivivisectionist pressures to avoid animal research should not be permitted to place patients at hazard.

**Field Strength**

This is a curious and subtle aspect of surgical innovation. In the late 1940s and early 1950s, several clinical departments of the Harvard Medical School at the Brigham Hospital (Boston, Mass) enjoyed a long experience and collaborative tradition in the field of chronic renal disease and transplant immunology, which was then an infant field. Dialysis on the artificial kidney was available and frequently used. The totality of this effort provided field strength relative to kidney transplantation and chronic renal failure, with clear appreciation not only of possible benefits but also of complex risks. This was an ideal situation of field strength for the exploration of kidney transplantation.

The same sort of field strength might be available for innovations in the surgical treatment of heart disease, central nervous system disease, vascular disease, or cancer treatment. If an innovative operation is to be performed, it should be done in an institution with this sort of field strength, but above all with congenial consultative traditions between the various clinical and basic sciences involved.

**Institutional Stability**

Innovative operations, whether they be minor improvements or massive new changes, should be carried out in a hospital where there is sufficient support for undertaking such a step. Surgeons and medical school support staff should have known each other, worked together, and have the sort of stability and historical record that provides security for the patient and reassures the anxious family. In advocating a new procedure, the surgeon will often arouse strong negative feelings amongst those colleagues who are not yet ready for change, not informed of the details, or not familiar with the experimental background. Despite this difficulty, some sort of consensus should be attained.

Institutional strengths also include capabilities such as supporting services, the blood bank, chemistry and pathology services, intensive care, operating room management, and the attitude of the institutional leadership toward innovation. Explanations to the family should not be haphazard but should reveal all aspects of the problem at hand and the plans being made. One of the most senior of the team, a person in authority, should have the responsibility of explaining plans to the family.

It is easy to call in an outside expert in consultation. It is sometimes more difficult to call in the surgeon’s own peer group, some of them possibly professional rivals. Yet these colleagues are apt to understand the suitability of the clinical and institutional setting far better than an outside expert. Research studies and follow-up that will reveal the success or failure of the new procedure should be undertaken from the beginning.

**MANAGED CARE: PATIENT SELECTION AND CLINICAL DECISIONS**

The ethical questions of managed care are simple to enunciate: Is it appropriate for a corporation of laypersons, even with the help of a few physicians, to set the ground rules for the selection of persons to be enrolled as patients and for clinical decisions in their care? Can a surgeon ethically yield these 2 ancient prerogatives—selection and decision—to the dictates of a corporation?
Can he or she ethically exclude needy patients from care and relinquish independence?

The professional skill, education, and experience of the surgeon and consulting physicians provide security for the patient. The conflict between corporate objectives and professional ethics in managed care is most apt to be severe in enrolling patients who suffer from chronic diseases and those who are near or below the poverty line, as well as in clinical decisions concerning expensive or innovative procedures.

To remove the corporate ethos from this area of clinical decision-making, it is important for physicians to establish a relationship to the managed-care corporation (the insurer) that clearly separates their professional function from the commercial ambitions of the insuring corporation. One method of creating this relationship is to "decouple" physicians as a working group from the insurance agency. Here, the physician group contracts with the insurance arm of the corporation to care for the enrolled patients. The physician group retains complete clinical responsibility, unbiased by the business concerns of the insurer.

While such a decoupled contract gives the physician total responsibility for clinical care, it obviously places the burden of total liability for outcomes on the shoulders of the physician group.

If the insuring corporation steps in to modify professional decisions, the corporation must in turn assume liability for outcomes. The decoupled contract is favorable to physician authority, but also fixes liability. By the same token, if the insurer takes clinical authority to modify or propose treatment, then the corporation must share liability for outcomes.

When corporations bias clinical decisions to suit commercial objectives, they become liable to litigation if the outcome is unfavorable. It is therefore in the best interest of the corporation, by fostering a decoupled contract, to turn the entire matrix of clinical decision-making entirely over to the authority of the physicians.

This still leaves unsettled the overarching questions of all-risk coverage, and community. Exclusionary coverage can remove many needy patients: needy either in the financial sense, or by clinical status or history. For any community, this enigma of incomplete coverage by managed care can only be solved by mandated risk sharing. Under such an arrangement, all managed-care corporations operating in a defined area are required to share risks jointly so that coverage of the community is as near to complete as possible.

Although the physicians remain apart from coverage selection in a decoupled contract, they must take the opportunity to negotiate completeness of community coverage so they are not bedeviled by a large residual cohort of patients in their community who are not covered by any sort of insurance and therefore require care from tax-supported institutions.

Any group of physicians working with managed-care corporations should keep a sharp eye on their all-risk coverage. They should be concerned about the extent of risk-sharing amongst the various managed-care corporations operating in the region. By the same token, state licensure bodies, in granting licenses to managed-care corporations in their state, should insist on risk-sharing so that the advent of managed care does not thrust an increased load onto tax-supported agencies such as city and county hospitals. The state licensure board should not tolerate leaving all patients with unusual health risks or families below the poverty line entirely to tax-supported care. This is particularly important because the participation of tax-supported agencies such as welfare, Medicaid, Medicare, and other state and federal programs will be critical to the success of the managed-care sector.

State licensing boards should insist by law and regulation that managed-care corporations licensed in their state do not become merely "group practices for the care of the well and the wealthy." By sharing coverage of high-risk groups and accepting joint coverage of these groups, the needs of the community can be met by managed-care corporations. Unless the managed-care industry accepts this public responsibility, licensure should be denied. Enrollment policies should be examined by a public body. It is far too easy to profit from medical care if the expensive problems of disease and the poor are excluded.

Taxpayers themselves must keep an eye on this problem. If the taxpayers must pay premiums to a health maintenance organization for family care, they should not also be asked to carry an increased tax burden from the "dumping" of expensive treatment for poor families on their tax-supported facilities such as the city or county hospitals.

CONCLUSIONS

The ethical problems incidental to teaching and innovation exist throughout medicine. The very nature of surgery makes these ethical problems especially prominent for the surgeon. In addition, the managed-care environment puts at risk the surgeon’s professional commitment to all-risk coverage, to the care of the poor, and to freedom of clinical decisions.

Corresponding author: Francis D. Moore, MD, Department of Surgery, Harvard Medical School, The Countway Library, 10 Shattuck St, Boston, MA 02115.