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WHAT restrictions would moral theology impose upon the surgical activity of student doctors in residency training? Apparently the question is of more than ordinary concern to physicians at the present time, since in varying forms it has been asked with a remarkable frequency within the past year or so.

The problem, as I understand it, emerges from an accumulation of several facts, the first of which is the imperative need that hospitals, for the good of medicine and consequently for the common good, engage in educational programs. Secondly, it is beyond question that a sine qua non of any such program is the provision of actual surgical experience for resident surgeons. And, thirdly, it is alleged that the number of service patients in some hospitals is not sufficient to provide residents with the amount of surgical experience desirable in the ideal order. Hence I am convinced that what doctors really want to know when they ask questions such as this is whether it is morally permissible to make use of private patients in the training of surgical residents.

For the sake of clarity let me suggest two hypothetical cases:

1) While traveling, Mr. A is stricken with severe abdominal pain and nausea. Proceeding to the nearest hospital, he is examined by an intern whose diagnosis of appendicitis is confirmed by a staff physician. Mr. A authorizes the hospital to provide surgery, and the appendectomy is performed by a resident surgeon under the supervision of his chief.

2) Advised by his physician that an appendectomy is imperative, Mr. B engages Dr. X, a surgeon of considerable repute, to perform the operation. Dr. X is present in a supervisory capacity during the entire procedure, but allows Dr. Y, a senior resident with a brilliant record, to perform the appendectomy.

Concerning each of these cases the question is the same: is the resident surgeon justified in doing what he does? Or perhaps the question should be worded: is the qualified surgeon justified in allowing the resident to do what he does in each case?

TWO RIGHTS OF THE PATIENT

In attempting to solve a problem such as this, the moralist would instinctively begin his thinking in terms of two fundamental rights of the surgical patient: (1) his innate right to be protected from all unnecessary surgical risk, and (2) his contractual right, if any, to be treated by the surgeon of his own choice.

Of these rights, the first is the

inviolable prerogative of any and all surgical patients, once they have been accepted as such either by an individual physician or by a hospital or clinic. The second, however, is properly reserved to the patient who de facto has engaged an individual surgeon for a particular operation — the so-called "private patient." The question of resident surgery will and must be solved according as these rights are respected or violated in particular cases.

GREATER RISK?

From a practical and realistic point of view, it would be silly to contend that greater risk to the patient is necessarily involved in every concrete instance in which a resident, rather than a qualified surgeon, is allowed to operate. The resident surgeon cannot be written off as a rank amateur. He is a doctor of medicine with a certain amount of surgical experience behind him. It is true that the resident is less experienced than the qualified practicing surgeon — and presumably the less capable of the two if one compares the totality of their respective surgical abilities. But that difference in *total* experience and skill need not necessarily be a vital factor in a certain number of particular surgical procedures, especially at the level of what doctors would consider routine surgery. Except for a certain facility and confident familiarity with which the more experienced man would approach such a bit of surgery, his work in a particular instance might not differ substantially from that of a resident under proper supervision.

It would be a different matter, of course, with more complicated or more delicate operations where high skill and long experience really count. But no conscientious surgeon would think of deputing that type of operation to a relatively unskilled and inexperienced underling.

The point to be made here is this: there are surely many cases where a staff surgeon could honestly and prudently judge that a certain resident is quite capable of performing a particular type of surgery without additional risk to the patient. Presumably this is the only kind of operation which a reputable surgeon would allow a resident to perform. Granted, therefore, a careful selection of cases according to the resident's known ability — and granted, too, proper supervision throughout the course of the operation — it is entirely possible that the patient's right to be protected from unnecessary surgical risk can be adequately safeguarded even when a resident surgeon is allowed to operate.

CONTRACTUAL RIGHTS OF PRIVATE PATIENTS

A considerably greater difficulty, however, is posed by the contractual right of the private patient to be treated by the surgeon of his own choosing.

By "private patient" I understand the individual who prior to surgery has explicitly engaged a specified surgeon to operate. That, I believe, is the generally accepted meaning of the term in contrast, for instance, to the service patient for whom the hospital, as authorized agent, provides a surgeon of its choice. To what is the private patient in justice entitled by virtue of the contract he has made with an individual surgeon?

Let us suppose that such a patient should expressly stipulate — as reasonably he might — that no one but the surgeon himself perform the actual operation. Would not the physician, once committed to the case on this explicit understanding, be in conscience bound to observe that part of his contract? Now even though that stipulation may seldom be expressly stated, to me it seems obvious that implicitly uppermost in every private patient's intention when he chooses a surgeon is the desire to secure for himself all the surgical skill (manual skill included) of this particular doctor, and not that of any substitute. Such a patient, I am sure, goes to surgery confident that the surgeon he has engaged will actually perform the operation, at least in its substantial essence. And if that is the service which the patient wants and for which he is paying, that is the service he is entitled to receive. Ultimately it is the violation of this right of the private patient to receive treatment from the surgeon of his choice that constitutes the essential malice of ghost surgery.

I have heard it suggested that all the patient really wants his surgeon to provide is successful surgery, regardless of the hand that performs it, and that implicitly he is willing to allow a resident to operate under the surgeon's supervision if in the latter's judgment the resident is competent. This interpretation of intention might possibly be verified in a limited number of cases, but to my mind presumption is very strongly against it. It certainly would not be my own intention if I as a patient were to make a choice of surgeon. Nor do I think that doctors themselves would readily undergo surgery on that understanding. And I doubt very much that a surgeon who might defend that presumption would agree to put it to the test by openly informing a patient that a resident would perform, or had performed, the actual surgery even under supervision.

It has also been alleged that, because the surgeon accepts all medical and legal responsibility for a resident's surgery, he has in no way betrayed his patient's interests. That argument is simply irrelevant. It is not only the surgeon's acceptance of responsibility for which the patient has contracted, but also the surgeon's own operating skill. To deny him the latter is a breach of contract.

Hence whatever concession may be made in regard to a resident's ability to perform certain operations without adding notably to the patient's risk, it cannot be said that no real injustice is done the private patient if, without his knowledge and consent, a resident is allowed to take the surgeon's place at the operating table. In all probability doctors would agree that the likelihood of obtaining explicit consent from a private patient for such an arrangement is at best minimal. And if private patients in general would be aghast

at the open suggestion that a resident be allowed to perform the operation for which a qualified surgeon is being paid, there seems to be no justification for proceeding on the basis of presumed consent.

RULING OF ACS

If in the opinion of some surgeons it savors of the ivory tower so to restrict the surgical training of residents, I can only refer them to the ruling of their American College of Surgeons. In December 1953, the Board of Regents of that College formulated definitions of several unethical practices, among them that of ghost surgery. Commenting on these definitions, Paul R. Hawley, M.D., wrote as follows:

> Their formulation was not accomplished without serious consideration of their impact upon wholly ethical requirements of surgical teaching and practice. The effect of the definition of ghost surgery upon resident training aroused the most concern; yet the Regents decided unanimously that honesty demanded that no exception be made in this respect. That good resident training can be provided within this limitation has been demonstrated.[1]

Five months later the Board revised its stand on the application of ghost surgery to residency training programs:

> The Board considers it to be a breach of ethics when any patient who has made an agreement with a surgeon is operated upon by another without knowledge and consent of the patient. However, the Board considers it proper for the responsible surgeon to delegate to his assistant the performance of any part of a given operation, provided the surgeon is an active participant throughout the essential part of the operation. *The Board of Regents approves the inclusion of all patients in residency training programs* (emphasis added).[2]

Finally one year later, as reported again by Dr. Hawley, the Board resumed its original position:

> On 7 December 1953, the Board of Regents of the American College of Surgeons adopted definitions . . . of four unethical practices. The Trustees of the American Medical Association concurred in these definitions.
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> A number of protests were made against the strict application of the definition of "ghost surgery" in the training of residents in surgery and the surgical specialties. In an effort to reconcile this definition with the realities of resident training, the Regents issued on 1 May 1954, a supplementary statement . . .
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> This latter effort, in turn, met with many objections from Fellows who wanted no compromise. The Board of Regents then turned for advice to a large and representative group of teachers of surgery. It was the consensus of this group that the original definition of "ghost surgery" is entirely applicable in resident training, and that no modification or explanation is necessary or desirable.
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> At its meeting on 4 June 1955, the Board of Regents rescinded its statement of 1 May 1954, and reaffirmed its earlier definition of "ghost surgery," which is: "*Ghost surgery* is that surgery in which the patient is not informed of, or is misled as to, the identity of the operating surgeon."[3]

In fairness and in courtesy to those who formulated the above statements, it should be kept in mind that these pronouncements were made by doctors, who naturally enough speak the language of doctors and not that of theologians. If, theologically speaking, these statements leave something to be desired, it is certainly not in a spirit of condescension that these deficiencies are remarked here. I want only to emphasize the fact that, while I agree with the ultimate conclusion of ACS regarding the restriction imposed upon resident surgeons, I do so by reason of a compelling moral principle and not because the policy appeals to me as merely the more honorable or the more expedient of two legitimate choices.

For one might get the impression from these several pronouncements of ACS that its opposition to residents' operating on private patients is not a strict issue of moral right and wrong, but only a matter of the better policy — something that could be legitimately decided, for instance, by a majority of aye's or nay's. One might also conclude that if residency training in surgery should in the future require it, this restriction on resident surgery could licitly be rescinded. Neither conclusion can be admitted if one concedes that, by virtue of the patient-surgeon contract, only the surgeon has any right to operate on his private patient. "The physician has no other rights or power over the patient than those which the latter gives him explicitly or implicitly and tacitly"[4] — and that is the natural-law basis on which my own conclusion stands.

SUMMARY

1) The lawfulness of permitting residents to operate on private patients will be determined by two natural rights which those patients possess: (a) the right to be spared all unnecessary surgical risk, and (b) the right to require of the contracting surgeon the total personal service which they reasonably expect.

2) The element of additional risk can be avoided if cases are carefully chosen according to a resident's recognized surgical ability, and if throughout the operation he remains under the supervision of a qualified surgeon. It should be conceded that surgical residents can be entirely competent operators in selected cases. Hence it is not necessarily inability which is invoked as the reason for denying them surgical rights with regard to private patients.

3) Consent of the private patient, however, to undergo surgery at the hands of anyone other than the contracting surgeon is a prime requisite for the lawfulness of this practice. Since it does not seem likely that this consent would ordinarily be given by the private patient for a resident actually to operate, presumption of that consent in ordinary circumstances does not seem to be justified.

CONCLUSION

On the strength of these premises, my solution of our hypothetical cases would be as follows:

1) The resident surgeon is morally justified in performing the appendectomy. Mr. A has engaged no surgeon of his own, but has authorized the hospital to provide a competent operator. On the assumption that the resident surgeon is prudently judged to be competent, no moral objection can be raised to his operating under proper supervision.

[1] *Bulletin of the American College of Surgeons* 39 (Mar.-Apr., 1954) 72.

[2] *Ibid.* (July-Aug., 1954) 152.

[3] *Ibid.* 40 (Sept.-Oct., 1955) 302. This directive was most recently reaffirmed *ibid.* (Sept.-Oct., 1956) 429-30.

[4] Pope Pius XII, *Allocution to First International Congress on the Histopathology of the Nervous System*, Sept., 1952. Cf. LINACRE QUARTERLY, Nov., 1952, p. 101.

2) Neither Dr. X nor Dr. Y nor the hospital can be justified in this case. The patient has contracted with Dr. X only, and cannot be presumed to consent to the substitution of the resident as operator, even under Dr. X's supervision.

While these two cases are more or less clear-cut, there are others which are not so easy of solution because they verge on the borderline. I refer to instances in which residents are allowed to *assist* at surgery performed on private patients. Certainly there is a considerable area within which no reasonable patient would object to a resident's lending the operating surgeon a helping hand. Everyone understands at least vaguely that surgery is not a one-man performance and that various assistants have to be on hand to relieve the surgeon of details extraneous to the actual operation. To know that another doctor, in the person of a resident, is standing by to help under the surgeon's direction would strike me as being more reassuring than disturbing to a reasonable patient, and something to which he would readily consent.

The difficulty here lies in determining satisfactorily the limits within which the resident can truly be said to be assisting at, and not actually performing, the operation. That is a question which the moralist must transmit to the surgeon — and perhaps even the surgeon can offer no more than a rough rule of thumb. One can, as did ACS, talk about "the essential part of an operation" (thereby implying parts which are less than essential), but what precisely that may mean in terms of a tonsillectomy, an appendectomy, a hysterectomy, etc., is not for theologians to define. But we would, I think, concede that if the surgeon himself performs what doctors generally would consider the substantial essence of an operation, he would be morally justified in supervising a competent resident's execution of other details.

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THE EVANSVILLE, INDIANA, GUILD reports that Dr. Thomas A. Dooley of *Deliver Us From Evil* fame, now engaged in Operation Laos in Indo-China, has been accorded honorary membership in the group. In addition to visiting the Mead Johnson Co. plant in that city before leaving for his mission, he met with the Executive Committee of the Guild and also lectured to Evansville physicians, clergy, and others. In his book this young Navy doctor gives a first-hand account of finding himself suddenly ordered to Indo-China, just after the tragic fall of Dien Bien Phu. In a small international compound within the totally Communist-consumed North Viet Nam, he built huge refugee camps to care for the hundreds of thousands of escapees seeking passage to freedom. Through his own ingenuity and that of his shipmates, he managed to feed, clothe, and treat these leftovers of an eight year war. Dr. Dooley "processed" more than 600,000 refugees down river and out to sea on small craft, where they were transferred to U. S. Navy ships to be carried to the free areas of Saigon. Not satisfied with past labors, Dr. Dooley has returned to Saigon, Viet Nam to give further assistance. The Mead Johnson Co. has provided him with vitamins and other products to use on his Operation Laos.