SURGICAL ETHICS CHALLENGES

Patient responsibilities, family responsibilities

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As a senior partner in your area's leading vascular surgical group, you've repaired a thoracoabdominal aneurysm this morning on an otherwise healthy 75-year-old woman using a thoracoabdominal incision and left-heart bypass. The operation went well, with the patient regaining consciousness, moving her lower extremities, and being extubated before you left the hospital for the day at 6PM. Clotting studies were normal and there was less than 200 mL of chest tube drainage. This evening you are preparing to accompany your wife to a banquet at which she'll receive an award from her professional association. You receive a call from the ICU reporting that the patient's chest tube drainage was 600 mL over the last hour. The equally experienced vascular surgeon who assisted you in surgery is taking call for the group this evening. What should you do?

A. Return to the hospital and take care of the problem.
B. Tell the ICU staff to look more closely at the on-call schedule and to page the proper surgeon.
C. Page your on-call partner, explain the situation, and ask him to accept a transfer of responsibility for the case during the on-call period.
D. Go to dinner with your wife and plan to look in on the patient later.
E. Tell the ICU nurse to repeat the clotting studies, monitor the output carefully, and call you in 2 hours.

The best response is C. D is the least acceptable.

The physician has fiduciary obligations to his or her patient and must therefore accept protection and promotion of the patient's health as primary concerns and commitments. In this life of service, protection and promotion of the surgeon's self-interest become necessarily and systematically secondary. The fiduciary role is largely defined by such professional virtues as integrity (practicing medicine to standards of intellectual and moral excellence), compassion (empathic therapeutic response to pain and suffering), self effacement, and self sacrifice (of time, effort, convenience, and even health to meet patient needs).[1]

The first virtue, integrity, does not admit compromise. Compassion must be modulated by sufficient dispassion to permit effective action in emotionally laden situations, but it is ultimately the motivating principle of the medical profession. Self effacement and self sacrifice, by contrast, have limits, and their limits are as ethically necessary as their obligations. The totally self-abnegating surgeon would soon become an exhausted, overwhelmed, and ineffective surgeon, capable of serving neither the interest of others nor of himself. Making reliable judgments about when self interest should be protected and fiduciary responsibility limited can be one of the physician's most difficult ethical challenges. Because the surgeon's role can so often affect a patient's actual survival, the weight of these decisions can be particularly heavy upon our specialty.

Given its relatively greater time requirements, the frequency of unanticipated emergencies, and its demands upon the physician's physical as well as intellectual stamina, the practice of surgery will place extraordinary stress upon conflicting obligations. All of us have lives outside of medicine, and in our capacities as spouses, parents, children, siblings, and friends we incur moral responsibilities, just as we do in our roles as surgeons. The ethical obligations attendant to those relationships are part of what define us, and everyone expects us to honor them. It is unlikely that many of our patients could be comfortable in their trust of us if we were known to behave irresponsibly in all of our other interpersonal transactions. Fulfilling significant obligations in our family and social lives contributes to the sense of self respect and self confidence that every surgeon knows is essential to the practice of our craft; if it happens that we derive personal satisfaction and enjoyment from doing so, and from otherwise finding respite from our uniquely demanding work, we strengthen ourselves.

Returning to the hospital immediately in response to the call, choice A, would disappoint your wife on an important occasion and ultimately violate your ethical obligation to provide her with emotional support, particularly at significant junctures in your life together. Although a surgeon's spouse has likely suffered many such disappointments and knows there will be more, our families are entitled to have their own realistic expectations met when

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other options are available for managing patient emergencies.

Petulance and impatience with the ICU staff (choice B) will neither resolve the problem nor earn you their improved future cooperation. The staff is correct in first calling you as the attending surgeon to determine how you want the patient care problem handled.

Choice D, honoring your obligation to your wife but thoroughly abrogating your responsibility to a patient with an impending emergency, clearly exceeds the legitimate boundaries of protected self-interest in surgical practice. The surgeon may ethically pursue his self interest only after the interest of his patient has been assured.

Temporizing by ordering redundant tests and observation (choice E) to briefly extend the time you can spend with your wife is clearly poor medical practice and probably poor home practice, because neither patient nor spouse will receive the full measure of attention to which they are entitled.

Transferring care to a competent surgeon who knows this case and with whom you have recently reviewed it (choice C) is likely to effect as satisfactory a result as if you went in and handled it yourself; ensuring a good outcome for the patient is the crux of this ethical and clinical dilemma, not who must be most self-abnegating. The on-call system as it is designed throughout the medical profession is intended to substitute one physician's abilities for another's and provide all with opportunities for scheduled rest and recreation. The steps you would take to gain control of this complication (repeat clotting studies, drainage monitoring, CXR, medical management, or return to the OR as indicated) are those that would be taken by virtually any surgeon in attendance. If there were an idiosyncrasy of this patient, or a feature of your operative technique, which you are uniquely equipped to address in the face of this complication, then you are ethically obligated to go to the hospital and take personal charge of the case management. If you can otherwise ensure a satisfactory outcome and maintain your obligation to a family member, your decision to do so is ethically correct.

REFERENCES

1. McCullough LB, Jones JW, Brody BA. Principles and practice of surgical ethics. In: McCullough LB, Jones JW, Brody BA, editors. Surgical ethics. New York: Oxford University Press; 1998. p. 3-14.