SURGICAL ETHICS CHALLENGES

James W. Jones, MD, PhD, MHA, Surgical Ethics Challenges Section Editor

Are ethics practical when externals impact your clinical judgment?

James W. Jones, MD, PhD, MHA, and **Laurence B. McCullough, PhD,** *Houston, Tex*

Every man is a damn fool for at least five minutes every day. Wisdom consists in not exceeding that limit.

Elbert Hubbard

You were somewhat flattered when the foremost donor to the hospital where you practice consulted you 6 months ago for an infrarenal aneurysm. He is 85 years of age and has enjoyed fully his leisurely lifestyle. In the interim he has pledged to fund a much needed hospital children's wing. The aneurysm measured 4 cm then. When he came in for a 6 months' checkup, the same equipment was used to measure and the aneurysm remained exactly the same. Both he and his wife are adamant that their lives have been tormented continually by the presence of a "weak spot that could rupture and kill him." Your citations of data, reassurances, and pleadings for reason were unheeded. You agreed to fix it. The hospital administrator and chief-of-staff called to congratulate. The preoperative workup had no imposing data to rethink operating and children and influential friends have flown in to be attentive. But you continued to be troubled. What should be done?

A. Do the procedure. You agreed.
B. Get called out of town for a family emergency and have one of the equally experienced colleagues who congratulated you do the procedure.
C. Do the procedure. A generation of patients will benefit from the new hospital wing.
D. Do the procedure. The emotional suffering of that elderly couple makes up for the slight disadvantage of a tilted risk/benefit.
E. Don't do the procedure. Your integrity depends on objectively practicing evidence-based medicine.

From The Center for Medical Ethics and Health Policy, Baylor College of Medicine.
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Correspondence: James W. Jones, MD, PhD, MHA, 31 La Costa, Montgomery, TX 77356 (e-mail: jwjones@bcm.tmc.edu).
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In a modern medical environment, high-profile physicians encounter all kinds of external pressures; there always have been. Political pressures about what to do or say draws on time and energy, and special patients with claims or special requests make an elite practice "interesting." In contrast to the interesting cases of medical students, to experienced surgeons the designation "interesting" usually euphemistically means an association with sphincter tetany. In this case, the interesting portion is ethical not medical.

Major vascular surgery has accomplished miracles in the last half of the preceding century but those procedures remain attended by horrific complications. It is therefore important to be certain that the risk-benefit ratio for each patient is clearly beneficial. Otherwise, the surgeon's beneficence-based obligation to protect the health and life of the patient is violated. Professional integrity prohibits such violations. Externalities, such as the hospital's quite legitimate self-interest in securing funding for its expansion, do not override this integrity-based ethical prohibition.

Maintenance of professional integrity and the protection of patients from clinically unnecessary and, especially, unnecessary and potentially harmful interventions provides the basis of patients' trust. Patients who are considering major operations have a great deal of trust, frequently unreasonable, in what their surgeon can do and what their outcome will be.[1] The physician is and should remain someone worthy of intellectual trust—to practice medicine to evidence-based standards—and moral trust—not to allow matters of individual or organizational self-interest, however legitimate, to distort or undermine adherence to those standards.

Because vascular surgeons are conclusive referral specialists, they are less likely to receive patient's requests for tests or procedures, but the era of patient participation in their medical care is upon us. Kravitz[2] noted 5 years ago that one third of patients requested specific tests or procedures and 9.6% of physicians complied. Another study determined that when physicians were confronted with requests for unindicated magnetic resonance imaging scans, 8% ordered the expensive tests, 22% stated they would order them in the near future, and 53% ducked the issue with a pointless referral to a neurologist.

It sometimes appears that government, patient advocates, insurance payors, national medical organizations, and a growing number of ethicists have hopped on the autonomy bandwagon and increasingly insist that patients should not only be accurately informed and participate in decision-making about their treatment but should also be deciding their therapy. The pharmaceutical industry recognizes the emergence of "power to the patient" by peppering the airways with enticements pressuring patients to pester physicians for life-enhancing supplementary drugs that do not treat diseases. They legitimize these ads by providing a mini-medical education, including contraindications and side effects that patients generally ignore or may even find desirable. What impotent lay male, when warned about erections lasting 4 hours, would not confuse satyriasis (good) with priapism (bad) unless told that his penis could thrombose and require amputation. Talk about polysemous advertising!

More than a decade ago, Pellegrino[3] cautioned that undue enthusiasm for patient rights could be harmful to their health, when he warned:

> In the last 25 years, patient autonomy has displaced physician beneficence as a dominant principle in medical ethics. This has enhanced the moral right of patients to refuse unwanted treatment and to participate in clinical decisions. But now, in some cases, patient autonomy is being absolutized. The right to refuse is becoming a right to demand treatment. The result is danger to the moral and professional integrity of physicians. A reassessment of the mutual moral obligations of physicians and patients to respect each other's autonomy is in order.[3]

That reassessment has involved making the distinction between negative and positive rights. A negative right is the right to be left alone. Negative rights shape the informed consent process. Once the physician has presented the adult, competent patient (and all adults are presumed to be competent) with the medically reasonable alternatives for the clinical management of the patient's condition, the patient has the right to select one of them or the right to reject some or all. Positive rights differ. A positive right includes the right to identify for oneself what clinical management is reasonable and then request it. Because they place no or little demand on the resources of others, negative rights have no or only modest limits. By contrast, positive rights do place demands on the resources of others. Positive rights always come with limits. The ethics of positive rights concerns what those limits are, not whether they exist in the first place.[4]

The distinction between positive and negative rights may be lost on some patients. Physicians, however, should never lose sight of the distinction, lest they prefer to abandon professional integrity and become mere technicians of medical knowledge and its clinical application.

In this context, it is crucial to appreciate that when one grants the right for a patient to direct their own therapy, recognition must be given to the fact that the patient's values may directly conflict with the physician's values.[5] Evidence-based practice of medicine cannot be understood completely, much less mastered to proficiency, by a highly intelligent layperson querying the Internet. Were you to explain the disease and therapy using advanced technical terminology to such a patient, their understanding would be the equivalent of showing card tricks to a dog.

Beneficence-based surgical judgment is the linchpin of surgical therapy, absent which deficits accrue that technical skills cannot overcome. A perfectly performed unnecessary procedure remains unnecessary. The extent to which the patient's autonomy allows modification of the surgeon's best judgment soon becomes paradoxical, wherein something good chances becoming bad. Surgical judgment thus must be mindful of when respect for autonomy has gone too far and trodden beneficence must kick back in. That point is reached when the patient asserts positive rights to treatment for which there is no adequate evidence base and that is potentially harmful. Because then providing such intervention violates beneficence-based obligations to the patient and therefore professional integrity.

Recommendations for treating abdominal aneurysms are current and devised by respected authorities who have evaluated the available evidence.[6] Our patient's disease is less severe than the authoritative recommended threshold for repair, and his advanced age, along with follow-up evidence of disease stability, provides a foundation for our surgeon's rethinking his decision to operate. The recommendation of the Joint Vascular Council's subcommittee includes considering the patient's preference in the decision to operate or monitor, but one may assume the patient's positive rights apply to borderline cases and do not trump unfavorable risk-benefit ratios.

Excellence in the practice of evidence-based medicine requires a continuous readjustment of decisions as data input changes. Rethinking decisions becomes absurd unless one includes willingness to alter previous conclusions. Changing the decision to operate will be embarrassing for the surgeon and inconvenient for the patient and his family. But is doing an operation for what one has decided is the wrong reason less important? One would suspect that the ego strength of our surgeon would suffice; the ego appears the most regenerable part of the human psyche. Option A cannot be considered correct.

Getting another willing surgeon to take over a Jehovah's Witness case is ethically acceptable, why not this case? As the responsible surgeon, you cannot disregard the fact that by making arrangements for the procedure, you will still be responsible for an unindicated procedure being done.[7] Should you refuse and the patient seek another surgeon himself, you would not be at fault.

Option B has entertainment value and we have heard it mentioned as such by students in our teaching of cases like this. Option C has no legitimate palace in the decision-making, inasmuch as it represents a transparent failure of professional integrity. Utilitarianism by definition slights the physician's ethical duty to patients by placing emphasis on the "greatest number". D as a choice is insufficient to validate the performance of the operation and should be dealt with by a careful explanation of the relative risks, a

recommendation against surgical intervention at this time, and psychologic reassurance of closer follow-up. The same is the case for option A.

The remaining choice E is to cancel the procedure and is the ethically correct one. It is difficult indeed to disregard worldly importance and not allow it to influence our clinical decisions, but it matters not whether bad judgment arises from insufficiency of knowledge or unwarranted influences, it pollutes all the same.

REFERENCES

1. McKneally MF, Martin DK. An entrustment model of consent for surgical treatment of life-threatening illness: perspective of patients requiring esophagectomy. J Thorac Cardiovasc Surg 2000;120:264-9.
2. Kravitz RL, Bell RA, Azari R, Krupat E, Kelly-Reif S, Thom D. Request fulfillment in office practice: antecedents and relationship to outcomes. Med Care 2002;40:38-51.
3. Pellegrino ED. Patient autonomy and the physician's ethics. Ann R Coll Physicians Surg Can 1994;27:171-3.
4. Minkoff H, Powderly KR, Chervenak F, McCullough LB. Ethical dimensions of elective primary cesarean delivery. Obstet Gynecol 2004;103: 387-92.
5. Blustein J. Doing what the patient orders: maintaining integrity in the doctor-patient relationship. Bioethics 1993;7:290-314.
6. Brewster DC, Cronenwett JL, Hallett JW Jr, Johnston KW, Krupski WC, Matsumura JS. Guidelines for the treatment of abdominal aortic aneurysms. Report of a subcommittee of the Joint Council of the American Association for Vascular Surgery and Society for Vascular Surgery. J Vasc Surg 2003;37:1106-17.
7. Jones JW, McCullough LB. Religiously-based treatment refusal. J Vasc Surg 2001;34:952.