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Consent for residents to perform surgery

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A senior member of the Board of Trustees at your University Hospital has asked to see you in consultation. After studying his diagnostic workup, you will recommend that he undergo an open infrarenal abdominal aneurysmectomy. As usual, a surgical resident will be assigned to perform the procedure under your supervision. The operation will count as an index case for the resident's board credit. Which of the following should you tell the patient during the informed consent process?

A. That vascular surgery is a team effort and you are the captain of the team.
B. That a supervised resident will perform and be credited for the procedure.
C. That you will be performing the surgery with the involvement of a trainee.
D. That your morbidity and mortality rates with assisting residents for this procedure are excellent when compared with national averages.
E. That you appreciate his special status in the hospital and will not impose upon his busy schedule by describing procedural details he is surely familiar with.

The best answer is B; the least ethically acceptable response is C.

The medical profession has an ethical and social obligation to educate physicians and surgeons to meet the needs of future generations of patients. The compelling need to train our successors was articulated by the author of the Hippocratic Oath in the fifth century BC, and it was probably well established long before that. Our responsibility to prepare students, residents, and fellows to practice independently and competently requires that we provide them with opportunities to assume graduated responsibility for the assessment and care of patients, while ensuring that the patients we entrust to trainees are treated safely and effectively.

The first teaching hospitals in America were modeled on the British infirmaries and funded from public and private sources. These hospitals provided free care to the poor and were seen by academic physicians as training sites where a presumed sense of reciprocity would obligate indigent patients to willingly serve as teaching material in exchange for their care.[1] This assumption is now considered incompatible with the process of informed consent, which is understood to include the patient's awareness and agreement that trainees may participate in his care. The American Medical Association Council on Ethical and Judicial Affairs has established a clear position on the relationship between patients and trainees on clinical rotations: "Patients should be informed of the identity and training status of individuals involved in their care, and all healthcare professionals share the responsibility for properly identifying themselves."[2]

The prevailing ethical measure for disclosure in the informed consent process is referred to as "the reasonable person standard."[3,4] This guideline effectively obligates the physician to provide the information that any reasonable person in the patient's circumstances would need to know, and that the layperson of average sophistication should not be expected to know, to make an informed decision about pertinent treatment options. Patients need to know about the nature of their surgical procedure, who will perform it, and the benefits and risks of the operation.

Choice A, substituting reassuring homilies for specific information, deprives the patient of information he needs under the reasonable person standard and diminishes his ability to make an informed decision about whether to proceed with the operation you are planning. In this case, such an approach skirts discussion of the resident's actual role and is essentially misleading.

Choice C, informing the patient that you will be the primary surgeon and that the resident will be only vaguely "involved" in some implied minor and inessential capacity, clearly misrepresents both the resident's function and your own. Although this characterization of the surgical resident's work in the operating room remains the standard of disclosure in many teaching hospitals, it does not meet the reasonable person measure, which assumes that the information provided to the patient will be neither untrue nor designed to be misunderstood. Before the patient can accept the role of *teaching subject*, he must be made aware that he has been offered the part.

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Choice D is not an adequately complete disclosure of operative conditions. Although pertinent morbidity and mortality rates are important in the surgical consent process, your own outcome data are not the salient statistic in this case. Even with close supervision, a resident's work at the operating table can add an increment of risk to surgical care. Infrarenal aneurysmectomies, for example, run an average of 73 minutes longer when performed by surgical residents.[5] Citing your own outcome data when you will not be the primary surgeon obfuscates the resident's relative inexperience and deceives the patient by guiding his attention away from a key risk element to which he might reasonably object.

Choice E, assuming that your patient's association with the hospital obviates the need to explain procedural elements of the operation to him, can actually deprive him of his entitlement to informed consent. Even when the sign over the door reads, "University Hospital," the layperson of average sophistication should not be expected to intuit that an incompletely trained surgeon will be performing his surgery. And even though this patient sits on the hospital's governing board, we should not presume that he is closely familiar with the structures and practices of surgical training. It has long been acknowledged in medical practice that VIP status guarantees that a patient will receive substandard care. Show this patient the respect that you give every patient, and remember that the well-honed standard practices of the informed consent process ensure that all patients receive the information they need to make critical decisions.

Choice B, explaining that a surgical resident will perform the key elements of his operation under your direct supervision, provides the patient with an accurate account of what is planned, assures him that a senior surgeon will be present to offer guidance and control risk, and establishes that this is a regular and fully transparent method of clinical care and surgical training. The patient so informed will have an opportunity to explore his questions, including any misgivings, with you and assess his choices in the manner typical of reasonable people.

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