

Chapter 53
Ethical and Legal Considerations

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CONSIDERATIONS FOR SURGEONS

GENERAL CONCEPTS

Defining the Problem

Professional responsibilities have been a concern of surgeons since antiquity; however, the last 25 years have displayed a dramatic growth of both professional and societal attention to moral and ethical issues involved in the delivery of health care. This increased interest in medical ethics has occurred because of such factors as the greater technological power of modern medicine, the assigning of social ills to the responsibility of medicine, the growing sophistication of patients and the information available to them, the efforts to protect the civil rights of the increasing disadvantaged groups in our society, and the continued rapidly escalating costs of health care including medical malpractice costs. All of these factors contribute to the urgency of dealing with ethical and moral issues involved in the delivery of modern surgical care.¹

The terms *ethics* and *morals* are often used interchangeably to refer to standards regarding right and wrong behavior. *Morals* refer to conduct that conforms to the accepted customs or standards of a people. They vary with time and with the nature of society at that time. *Ethics* is the branch of philosophy that deals with human conduct, and can be described as applied morals. *Medical ethics* refers to the ethics of the practice of medicine. *Clinical ethics* refers to the ethics of delivering patient care. The term *bioethics* includes the ethics of all biomedical endeavors and encompasses both medical and clinical ethics.² The *law* serves to delineate the *formal rules of society*. It expresses a kind of minimal societal ethical consensus, which society is willing to enforce through civil judgments or criminal sanctions. The law does not always prohibit behavior deemed unethical, however it will usually set a minimal standard for conduct. Those of us who practice clinical surgery often have trouble differentiating *ethical issues* from *legal issues*. It will be the purpose of this chapter to clarify this dichotomy. It should be stated from the outset that it is more important to understand the process of dealing with these issues than to assume that anyone can clearly state what is ethically right or wrong in a complex medical/surgical dilemma. The law, on the other hand, can be very explicit and can vary from state to state.

Surgeons live and practice an intense form of applied ethics. We deliver bad news; we guide patients and their families through complicated decisions to arrive at appropriate informed consent; we live a code of truth and trust among ourselves, our patients, and our trainees; we must deal with the end-of-life issues; and we make plans for extended, palliative, and hospice care. Finally, as only we

surgeons know, we must go to bed at night knowing that in the morning we will spend hours with someone's life literally in our hands.

In recent decades, although we can technically and scientifically do more for our patients than ever before, our personal, trusting relationship with them has deteriorated to the point where it is sometimes adversarial. We have allowed medicine to become a business, guided in many cases by the financial bottom line, rather than by the uncompromising concern for a sick person. Within this fast-moving corporate system, we see too many patients, do too much surgery, and do not have time to develop a close mentoring relationship with our chosen role models, nor with our trainees.³ The cherished patient physician relationship has been undermined by our own successful advances. Many of the operations that we do on a routine, daily basis were not even imagined as possible only a few decades ago. Not only can we do more, but also our patients have come to expect perfection from us. Our society seems willing to accept flaws from many sources, but not from physicians and medical delivery system. This situation is made even more complicated by a system in which individuals purchase their health care coverage when they are well and willing to buy the cheapest plan possible; but they utilize their coverage, especially for surgical problems, when they are sick and want the maximum that the system can deliver, without regard to time and cost. No individual has ever admitted that he purchased a cheaper plan and, therefore understood that only limited care should be provided to a love one who is ill.

Despite these difficulties, we surgeons cannot abandon the needs of our patients and their families. To help them make informed choices, we must communicate completely and compassionately the requisite information about the disease, treatment options, and long-range plans. To do so, we must learn and apply the ethical principle of *truth telling* and the doctrine of *informed consent* for the effective care, which has taken us so long to master. We must also take into account that high-speed communication via the Internet will necessitate reevaluation of issues such as *patient's rights* and *confidentiality*. Surgeons must lead in forging this new era rather than leave it to bureaucrats, politicians, lawyers and others not intimately involved in patient care.

We cannot rely on intuition or on our own personal value system. Learning the ethical aspects of delivering patient care must become an integral part of the surgical training program, and we must be held accountable for mastering the skillful application of these bioethical principles. After all, the concept of good clinical medicine and surgery implies the best use of scientific, technical, and *ethical* considerations. Just as with medicine and science, bioethics and legal underpinnings of bioethical decision-making are evolving all the time. In this chapter, we will not discuss all possible bioethical issues, but will limit ourselves to

those, which may be of concern to colon and rectal surgeons and to surgery in general. Important issues relating to such matters as professionalism, research ethics, family, business and financial pressures, genetics, and reproductive considerations will be discussed, as well.

What Makes The Surgeon Special?

Undergoing major surgery is an extreme experience, which changes people's lives. Surgeons are repeatedly involved in these extreme experiences of others. That makes surgeons uniquely placed among healthcare professionals to understand the experiences of their patients.

Miles Little explains that there are special ethical considerations for surgeons.⁴ These include: Rescue, Proximity, Ordeal, Aftermath, and Presence. These terms help to define the ethical relationship between the surgeon and his or her patients. Rescue, he describes as the first pillar of surgical ethics. It deals with the fact that surgery conveys power, and that power is socially endorsed and may be reinforced by the surgeon's individual charisma; but as with all power it must be constantly renewed and re-validated. Patients have no choice but to acknowledge surgical power when they consult a surgeon. There is always an element of surrender in the surgical relationship, but it is a surrender that presupposes rescue. Accepting rescue as a legitimate principle justifies respect for dependence in the surgical relationship. Surgeons, themselves, sometimes need help and rescue from colleagues when they have trouble with complicated diagnosis, management, or operative procedures. Proximity occurs in surgery as in no other act. To operate on persons involves entering their bodies and becoming privy to secrets even denied to the owner of the body. Little states, "To get to my body, my doctor has to get to my character. He has to go to my soul. He doesn't only have to go through my anus." This proximity to the patient can make special ethical demands on the surgeon. This proximity carries with it the penalties of closeness, and particularly the pains of failure. Some surgeons find that distancing themselves from their patients makes failure easier to bear. Understanding the privileges and risks of proximity is critical for the compassionate surgeon. Ordeals are periods of extreme experience, capable of disrupting our lives. The author, Little, explains that all medical encounters are ordeals. Patients yield autonomy, acknowledge dependence, place trust, face risk, confront embodiment and mortality, lose control over time and space, experience alienation, pain, fear, discomfort, suffering, and boredom. Surgeons observe and participate in the lives of patients with serious illnesses. A surgeon, who understands the ordeal of the surgical episode, can better help his or her patient through such extreme experiences. Aftermath deals with the reality that surgery leaves physical and

psychological scars that may persist for life. It is very difficult to communicate the concept of suffering to someone who has not suffered himself. Little describes surgeons as being in a unique position to understand the existential threats that their patients experience, the sense of mortality and bodily frailty they live with, and the difficulty of explaining extreme experience to others. When death approaches our patients, we must remember, not deny, our own mortality. Such an approach takes courage and a sense of personal security, and this does not suit everyone, neither patient, nor surgeon. Presence, as a virtue and a duty, is what the patient desires of the surgeon during all phases of the surgical encounter. Most surgeons have the stamina and cognitive ability to be present for their patients, but not all of us possess the personal attributes of charisma, confidence, energy, and empathy, which are necessary to engender *trust* from our patients and our staff. Sometimes, amazingly, our mere presence means more to our patients than defects in the manner with which we deal with them. Even if we can't teach sensitivity, we can emphasize the importance of surgical presence.

Thus, surgeons are privileged to lead lives of great complexity and moral richness. We can acquire a profound understanding and recognition of patient experience and suffering. Our proximity to patients seeking rescue, facing ordeals, and experiencing the aftermath of surgery, presents us with a great challenge.

UNIQUE PROBLEMS OF SURGERY

Surgeons, unlike other members of the health care team, take on a different level of responsibility as they encounter patients. For the surgeon the initial contact may just be the beginning of a longer-term relationship. With no previously established doctor-patient relationship, the surgeon and the patient may well be heading to the operating room for sometimes massive and sometimes potentially "futile" surgery. The surgeon and the surgical team take on the continued responsibility of the operative procedure itself, the postoperative care, and usually the long-term follow-up and management of any complications and dilemmas which may result from the initial encounter. This intense relationship is often established very quickly and under frequently adverse circumstances. The family and religion may not be known, the patient may be unconscious, and certainly will be once the procedure starts.

Arthur R. Derse nicely delineates the array of ethical issues that arise in delivering surgical care. These include: *informed consent, refusal of treatment, determination of decision-making capacity, treating patients despite their refusal, maintaining confidentiality while respecting the duty to warn others, limiting*

treatment over issues of "futility", treating pain at the end of life, and acting as a Good Samaritan. Unlike surgeons, people in most professions have the luxury of time, and the opportunity to redo their work in order to remedy any mistakes. Attorneys can appeal their cases. Accountants can file an amended return. Movie directors can yell, "Cut! Take two!" and re shoot the scene. All doctors understand that they will probably be second-guessed. As everyone who has ever watched a television police drama knows, the first thing a police officer must say to an arrested person is the famous *Miranda* warning. What most people don't realize is that the requirement for those warnings is the result of a Supreme Court decision rendered in June of 1966. As a practical matter, the court was telling the arresting police officer, in the heat of making an arrest, that he should have known something, which took the court system three years to contemplate and research. The bottom-line for surgeons who work under the same kinds of time pressures is to do what you think is best. You must use your judgment, based on your medical knowledge and your experience. You are on the front line, and you don't have the luxury of waiting three years for the Supreme Court to tell you how to handle a potential situation. However, you also want to be as scrupulous as possible in making sure that bioethical and legal guidelines are followed, both for the benefit of the patient, and, frankly, as protection for yourself.

While it is crucial for the practice of medicine in all fields to be familiar with bioethical concepts, it is unrealistic to be expected to be knowledgeable about the nuances requiring detailed understanding of controversial bioethical dilemmas. However, it is important for surgeons to have a working knowledge of general medical ethical principles and how these principles affect decisions involved with treating patients. Our goal will be to distill these general bioethical concepts and their underlying applications to specific situations, which you may face, into a cogent and concise tool for surgeons to use routinely, to include as part of their training, and to have as a reference resource. For specific dilemmas, time permitting, surgeons should obtain an opinion from the hospital ethics consultation service and/or from hospital counsel. By doing so, one can gain the experience and imprimatur of opinions from those who have dealt with such issues and whose training gives them the experience to deal with them in a knowledgeable way. It also serves as a cushion of knowledge for the physician when discussing the matter with a patient or the family. Surgeons should do all they can for the patient, while at the same time, doing what they need to do to protect themselves from personal risk and possibly from negative legal ramifications.

Similarly, doctors have a duty to themselves to avoid situations, which violate their own personal beliefs, whether religious or medical. This includes thinking a step or two ahead of the current situation to know what the

ramifications of a course of treatment may be. If the anticipated actions may violate a doctor's own personal tenants, he or she should refer the patient to another physician. The most obvious of these situations comes up with regard to religious beliefs. If, for example, a doctor has religious beliefs which would preclude withdrawal of life support, the doctor should be very careful about getting into a situation with a patient which might later dictate putting someone on life support. It may, down the line, become bioethically or medically appropriate to *withdraw* life support. If a physician cannot do that, she needs to know that up front and be prepared to withdraw from the case. A similar situation involves doctors who do not believe in abortion. They should not get themselves into medical situations where an emergency termination of a pregnancy may become the best medically viable option. You must always be prepared to protect yourself and your patients and must recognize your duties, both legal and ethical. You need to be aware of these duties and to avoid situations where they may come into conflict. This may be very difficult at times.

PRINCIPLES OF BIOETHICS

GENERAL CONCEPTS

Philosophical Principles

Two major fundamental theoretical philosophical concepts exist for constructing a theory of ethics: *deontologic* and *consequentialist*. A deontologic theory relies on rules while a consequentialist theory relies on outcomes.² From these theories are derived principles of ethics, such as those delineated by Beauchamp and Childress: respect for *autonomy* (patient self-determination), *beneficence* ("doing good"), *nonmaleficence* ("do no harm"), and *justice* (fairness).⁵

Respect for Autonomy

Adult patients with decision-making capacity have a right to their preferences regarding their own healthcare. This right is grounded on the legal doctrine of *informed consent*. This means that patients must give their voluntary consent to treatment after receiving all appropriate and relevant information about the nature of their problem, the expected consequences of the recommended treatment, and treatment alternatives.

This is probably the most crucial legal concept in bioethics. It simply means that you as a physician cannot *touch* a person without first getting permission, and without telling the individual of the possible ramifications of that "touching". Touching someone without his or her consent is, in legal terms, a "battery", which could result in a lawsuit for damages. Therefore, the principal is: medical treatment without consent is a battery. The first major case in this area said

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages... This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained."⁶ This case was decided before the concept of *living wills* and *durable powers of attorney* came into being. These documents both facilitate and complicate the consent process because *consent* must be obtained, if time permits, through these documents or via surrogate decision-making. Subsequent cases refined the requirements of consent to add to the concept of *informed consent*. The courts now require the patient not only to *consent* to the procedure, either themselves or through a proper surrogate, but to be given sufficient information to make an *informed* decision. The courts have held that the quality and quantity of information given to the patient must be sufficient for the reasonable patient to understand, not the doctor. The law has established the doctrine of the *reasonable man* to be used in deciding what is acceptable in many areas of delivering emergency surgical care.

Doctors are duty-bound to respect the autonomy of each competent patient. The patient is the ultimate decision maker about what he or she wants. The doctor may differ, even vehemently, with the patient's decision; however, the patient has the final say. There are exceptions to this rule also; such as the patient who demands a certain kind of treatment that the doctor knows will not be efficacious. Permitting *autonomy* to trump *nonmaleficence* poses a serious problem. A simple example of this is a patient who demands antibiotics to treat a viral infection. Giving the requested antibiotic complies with the *autonomy* principle; however, in the long run, it is conceivable that giving an antibiotic in such a case would violate the principle of *nonmaleficence*, would impose the concept of *futility*, and in the long run might enhance the capacity of bacteria to become resistant to certain antibiotics, thus even bringing into play the concept of *justice*. Even this simple example illustrates how medical ethical conundrums are frequently the result of *conflicting duties*.

If the patient is unable to make his or her own decision, the treating surgeon must respect the decision made by a surrogate decision maker, such as one designated in a healthcare *durable power of attorney*.

Beneficence

The principle of *beneficence*, simply stated, involves the duty of the physician to act in the best interest of his or her patients. *Beneficence* is *doing good*, and is the reason most of us chose to become doctors. *Beneficence*, or doing good, is probably the universal tenet of the medical profession.

Nonmaleficence

Nonmaleficence is essentially the old philosophical principle, "first, do no harm." It derives from knowing that patient encounters with surgeons can prove harmful as well as helpful. This principle includes not doing harm, preventing harm, and removing harmful conditions. For those physicians caring for patients in an emergency environment it also includes the concept of security, protecting oneself and one's team, as well as the patient, from harm.⁷

This concept also incorporates the principle of avoiding killing. This seems very obvious on its face value; however, what is a doctor to do when confronted with a situation where the administration of sufficient medication to alleviate the pain of a patient might have the secondary effect of diminishing respiration, and actually hastening the patient's death? This is, of course, the crux of the major debate that is ongoing over *physician-assisted suicide*, if not actual *euthanasia*. There are other situations where avoiding killing must be taken into account. Abortion presents another situation which, depending on your personal beliefs, might fall into that same category. This could create a conflict between the duty to respect the autonomy of the patient and the personal religious beliefs of the treating physician. This same conflict has recently, and intensely, come into play over the issue of research and therapeutic utilization of embryonic stem cells.

Justice

Justice is fairness. It is required to ensure that medical decisions are made with reason and honesty. Selfish or biased influences must be recognized and avoided.⁸ For many the term justice includes the concept of *distributive justice*. This form of *justice* includes not only the surgeon's obligation to an *individual patient* but to fairness in the allocation of resources for the good of the *broader society*. It is this concept of justice that becomes the basis for society-wide healthcare policy determination. *Distributive justice* implies that all individuals and groups should share in society's benefits and burdens. This presents an ethical challenge for the surgeon, dealing with an individual patient, who mistakenly believes that she should limit or terminate care based on a need to limit healthcare resource expenditures for the *good of society*.⁷ It was this temptation to place the good of society before the good of an individual that led the physicians of Europe to fall prey to the fallacious doctrines being promulgated by the Nazi government.⁹

Surgeons should be prepared to respect and seek to understand people from many cultures and from diverse socioeconomic groups. In the United States emergency facilities are obligated to provide necessary care to all patients,

regardless of ability to pay. Our current business-based medical delivery system makes it difficult to abide by the principle of having *access* to appropriate inpatient and follow-up medical care dictated by the patient's financial situation. Provision of emergency, and most elective, surgical treatment should not be based on gender, age, race, socioeconomic status, or cultural background. No patient should ever be abused, demeaned, or given substandard care.¹

Religion and Medical Ethics

In many societies, religion has been looked upon as the determinant of ethical norms. In our American Society, we are multicultural with no single religion holding dominance over the entire population. Therefore a value-based approach to ethical issues depends on the individual patient's values. However, religion still influences bioethical concepts and decisions. Clinical bioethics, in fact, uses many decision-making methods, arguments, and ideals that originated from religion. It is also important for the individual clinician to understand his or her own personal spirituality in order to relate better to patients and families, representing a broad diversity of religious and ethnic backgrounds. Although religions may appear dissimilar, most are based on some form of the Golden Rule, which holds "do unto others as you would have them do unto you." Problems frequently arise when trying to apply religion-based rules to specific clinical, ethical situations. In so-called modern times, the United States began turning away from a reliance on religious principles, relying instead for answers based on more generic secular principles; and the medical/surgical community was no exception. As previously described, we have come to rely instead on the four *ethical principles of autonomy, beneficence, nonmaleficence, and fairness*. These are the principles, which have guided medical ethical thinking and have become instrumental in forming healthcare policies in the United States and other Western countries over the past three decades.⁷

In a recent survey of physicians' attitudes toward spirituality in clinical practice, 85% said physicians should be aware of the patient's religious and spiritual beliefs. The survey went on to show that although many physicians believe that they should inquire about their patients' beliefs, fewer than 10% of doctors actually do so, even for their dying patients. There is no hard data to support the benefits of taking a spiritual history, but there is some indirect evidence in support of the practice. It is known that religion is one of the most common ways by which patients cope with medical illness. Religious beliefs are known to be significant influences on medical decisions, especially those made by patients with serious illnesses. In addition, the faith community is a primary source of support for many medically ill patients; and such social support is associated with better adherence to therapy and improved medical outcomes. Several surveys have

revealed that, from the patient's point of view, satisfaction with the emotional and spiritual aspects of care had one of the *lowest* ratings among all clinical care indicators and was one of the highest areas in need of quality improvement.¹⁰

The purpose for taking even a brief spiritual or religious history is to learn how patients cope with their illnesses, the kinds of support systems available to them in the community, and to learn of any strongly held beliefs that might influence the delivery of medical care. Venturing into this delicate area is obviously fraught with some hazards. We must be extremely cautious about prescribing religion to non-religious patients, forcing a spiritual history on patients who are not religious, causing patients to believe our practice and specific ways, attempting to provide spiritual counsel to patients, and arguing with patients over religious matters.¹⁰ It is also imperative for us as surgeons to be comfortable enough with our own beliefs to allow our patients to *pray for us*, according to the faith of their own religion. No comment more than a simple and sincere "thank you" is usually indicated.

LEGAL PRINCIPLES

GENERAL CONCEPTS

Types of Law

In the United States, law is created in one of two systems: *Federal* or *State*, and is made by judges (*common law*), legislatures (*statutory law*), and executive agencies empowered by legislatures (*regulatory law*). The fundamental document that creates and delineates these powers is the Constitution. *Civil law*, including malpractice, is usually enforced by *monetary judgments*. *Criminal law*, including physician-assisted suicide, is usually enforced by *finis* and/or *imprisonment*.²

There are three kinds of law, which affect the practice of surgery: *statutes*, *regulations* promulgated by an administrative agency, pursuant to a statute, and *case law*. The legislatures are the designated policy-making entities in our system; *regulations*, are written to comply with legislative directives; and the courts are charged with resolving disputes between parties, usually as directed by *statute*, if there is a relevant one. Courts issue written opinions when there is a conflict that results in a lawsuit, especially when the interpretation of a statute or a regulation is in question. The most difficult situations are those where the court is faced with a matter of "first impression," which the legislature has not specifically addressed. The courts, and their written opinions, on this type of case, frequently ask the legislature for guidance in future situations. Until the legislature acts, the written opinion of the court is the only guidance physicians have, and hospital counsel sometimes must interpret this.

Doctors should be generally familiar with *state law*. There are different state laws on many bioethical matters, such as definition of death, competency, organ donation, and now the use of embryonic stem cells, even for research only. Many doctors move from state to state during their careers, and general understanding of state laws governing situations which may confront them in surgical situations is crucial. However, most important legal principles that apply to ethical dilemmas in delivering surgical care are widely accepted among several states. There are some glaring discrepancies in these commonalities, including the neurologic *criteria for death* (a person may be legally dead in one state and not in another) and the legality of *physician-assisted suicide* (punishable as a crime in all states except Oregon).

Statutory Law

Statutory law is made by legislatures and includes such issues as *the statute of limitations*, which defines how long after an adverse event a patient is able to sue a physician for malpractice, and, in some states, statutes on *informed consent*.

The Emergency Medical Treatment and Labor Act (EMTALA) is another example of a *federal statutory law*. It was originally enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1986. Congress enacted EMTALA as a remedy for "patient dumping". The legislature was particularly concerned about hospitals refusing to render emergency care because of lack of insurance or the economic ability to pay, but soon came to realize that care was also being refused on the basis of race or other discriminatory criteria. The Act requires that a basic screening examination be provided to all patients seeking care. It therefore became illegal, as well as unethical, to withhold therapy from the poor just because they do not have the ability to pay.¹¹

Compilation of statistics from major county hospitals across the country concluded that as many as 650,000 patients were "dumped" annually; and the resulting transfer led to substandard care and or life-threatening situations in 25 to 33% of that number. The economic impact of EMTALA on hospitals and physicians has been enormous. Patients without the means to pay for medical care know that they cannot be turned away from the emergency room. Therefore, they use it as their *primary care facility*. That means that hospitals, physicians, and surgeons are carrying the burden of the nation's uninsured, often without adequate compensation. For many healthcare facilities, this money lost in the emergency room can mean the difference between bankruptcy and solvency.¹²

Regulatory Law

These administrative laws are created by regulatory agencies including State Medical Boards. Recent examples of regulatory law include not only EMTALA but also the recently implemented Health Insurance Portability And Accountability Act of 1996 (HIPAA). HIPAA, as EMTALA, was intended to protect patients' rights of privacy and to guarantee them continuation of health insurance coverage should they change employers. Also, like EMTALA, HIPAA has taken on many ramifications threatening a huge economic impact on the escalating costs of delivering medical care. Although the good aspects of it are necessary and noble, the burdens of increased costs will be crippling to some healthcare facilities and will probably significantly curtail many clinical research endeavors.

MALPRACTICE

The public and the legal community don't seem to understand that there is an element of uncertainty and unpredictability in a biological system. They seem to understand that eleven men on a playing field cannot score a touchdown on every play; but a surgeon is held to a standard of achieving perfection on every operation. An ethical, as well as legal, consideration is: what to do when we fall short of perfection or, worse, make a blatant error while trying to do the best we can. Several factors come into play. Who is responsible if you didn't actually do the damage yourself? What to tell the patient in the family? How you comply with the policies of legal counsel and risk management within your own institution.

Many successful legal actions against surgeons have been based on withholding information about risks, complications, or adverse outcomes. A surgeon must be able to admit to unwanted events in an honest and compassionate manner. It is clearly possible to accept *responsibility* without admitting *negligence*. It never hurts to admit that you are sorry things had not gone exactly as planned, but that you must go forward, as efficiently as possible, to correct the situation. At this point a surgeon should never hesitate to seek consultative assistance whenever it might seem helpful. It is never helpful to shift blame to a resident, an assistant, a nurse, a referring physician, or the institution itself. If anyone is to be sued, everyone will be sued; and divisiveness usually damages everyone. Unfortunately, it is also of little help to blame the patient and to invoke the existence of adequate *informed consent*. How nice it would be to tell the morbidly obese person that his postoperative complications should be blamed on his own indiscretions. Even informed consent, including risks based on the patients known status of precarious health, is of little help. A surgeon is not absolved of responsibility and concern by claiming, "I told you so!"

Judges, not the legislature, establish the standards that constitute medical malpractice. The familiar elements of medical malpractice include *duty*, *breach*,

causation, and damages. Decisions are based on the standard of care, and judges have developed the methods of determining the standards over many years, after the review of many cases. Thus, the courts rule on a specific set of facts that have already occurred. This is extremely frustrating for those practitioners of surgery who need to know what the law *would say* in a particular situation, as it is occurring, not in retrospect.

Unfortunately, resolution of controversy over medical and surgical ethical issues has been the domain of law, not philosophy nor medicine. So far, perhaps because of legal constraints, medicine has been unable to "police itself". Because the law has come to champion individual rights and hold physicians liable for malpractice, it has served to condemn medical *paternalism* as it has elevated *patients' rights*. This has had the damaging effect of encouraging many physicians to become more concerned with avoiding litigation than with "doing the right thing". The law has had understandable difficulty in sorting out the complicated *physician-patient relationship*, and thus law does not mandate ethical behavior in these relationships.

A FAMILIAR CASE-MANAGEMENT SYSTEM

PHYSICIAN-BASED ETHICS

General Principles

Mark Siegler, a physician, and his co-authors of "Clinical Ethics", the fifth edition, present a technique for using *case analysis* as a practical approach to solving ethical dilemmas in clinical medicine. Contrary to most texts on healthcare ethics that are organized around the ethical *principles* of respect for *autonomy, beneficence, nonmaleficence, and fairness*, their publication provides a straightforward *method* for clinicians to use in sorting out the pertinent facts and values of any case into an orderly pattern that facilitates the discussion and resolution of ethical problems.¹³ Their technique corresponds to the way in which clinicians usually analyze actual cases. It assimilates the ethical principles and circumstances that comprise a method to facilitate the analysis of cases involving ethical issues.

The *Clinical Ethics* System

Siegler and his colleagues suggest that every clinical case, especially those raising an ethical dilemma, should be analyzed by means of the following four topics: (1) *medical indications*, (2) *patient preferences*, (3) *quality-of-life*, and (4) *contextual features*, defined as the social, economic, legal, and administrative context in which they case occurs. The authors emphasize that although the facts of each case can differ, these four topics are always relevant. The topics organize

the various facts of the particular case and, at the same time call attention to the ethical principles appropriate for each case. Their intent is to show clinicians that these four topics provide a systematic method of identifying and analyzing the ethical problems occurring in clinical medicine. See Figure 53-1.¹³

We find it extremely helpful to utilize this case management system, which is very similar to our usual approach of managing a patient and his or her problem by taking a history in an organized fashion and proceeding to do a physical exam, analyze the laboratory data, and arrive at a plan for managing the case. Examination of the table shows that the authors have clearly related to clinical situations the basic ethical principles previously described. They go on to emphasize that most ethical conflicts can be resolved by falling back on the *medical indications* that represent the medical facts of the case. This information, plus the second category of *patient preferences*, almost always will lead the clinical surgeon to a resolution of the ethical problem. If the ethical dilemma results from conflict among the patient, the family, the health care team, or institutional policy, then adequate resolution may become dependent on applying analysis of the additional categories, *quality-of-life* and the array of *contextual features*. It is amazing how often reviewing and relying on what the medical facts of the situation actually are can clarify the intensity and emotion of even the most complex situation.

SPECIFIC DILEMMAS OF COLON AND RECTAL SURGERY

SPECIAL CONSIDERATIONS FOR COLON AND RECTAL SURGEONS

Attempting to explain, much less to justify, a career in colon and rectal surgery is never simple. The words, and the title itself, create consternation and the need to tell us the last circulating joke, which most of us have heard multiple times over. Telling what we do and who we are is never good dinner conversation and can present seemingly insurmountable challenges to represent ourselves at our children's eighth-grade career-day programs. We understand, however, that we have chosen a surgical career which includes resolving perplexing problems of anal-rectal disease, pelvic floor malfunction, and incontinence which cause daily significant discomfort for the patient and have frequently been mismanaged, for a long period of time, by our non-specialized colleagues. This places us, frequently, in the position of not only having to resolve the technical surgical aspect of the problem, but also having to explain the previous misdiagnosis or mismanagement by other physicians, a challenging *ethical dilemma*.

In addition to the seemingly simple anorectal disease, most of our careers also encompass management of some of the most complicated inflammatory bowel

disease and cancer. This casts us into a position of daily having to deal with multiple components of the modern health care team. We know that no one should ever have to die from colorectal cancer because it can be prevented or diagnosed at an early, or even premalignant, stage. Thus, we become actively involved with screening, preventive measures, understanding genetic predisposition to disease, and even the need for what has come to be called *preemptive surgery*. Because of the diseases that we treat, we must understand the science of current genetics as well as the appropriate clinical utilization of genetic testing, including the challenges of respecting *confidentiality* and requesting *genetic counseling* to deal with the long-term aspects involving not only the patient but family members who may not wish to be included in the discovery of genetic predisposition to disease. All of this presents intense need for dealing with frequent ethical challenges, especially the need for increasing *preemptive surgery*, subjecting a *well person* to major surgery with significant risk of complications or impact on lifestyle and body image. In fact, because of our experience and expertise in the construction and management of intestinal stomas, we are often confronted with such *quality-of-life* issues as body image and impairment of sexual function.

Dealing with our many patients, and their families, who have such inflammatory bowel diseases as Crohn's disease, requires us to maintain long-term, perhaps for generations, contact with and care for our patients, much the contrary of our public image of being just "technicians" who do a short-term repair job and then have no other, on-going relationship with our patients.

Because of the complexity of the diseases on which we operate, including those in areas with difficult access and high risk of postoperative complications and recurrence of malignant processes, we often find ourselves on the leading edge of surgical innovation and instrumentation. This creates the ethical challenges of differentiating acceptable surgical *innovation* from truly *investigative ventures* that require research protocols and institutional approval. We must deal with the interpretation and implementation of *autonomy verses paternalism* as we guide our patients to the best choices for their care. Sick patients and those suffering from advanced cancer will grasp at straws. They want anything on earth that might help. In such a situation, it is important for the surgeon-scientist to avoid exploiting this universal hope of sick patients by carrying out an operation that is inadequately tested.¹⁴ Because of these challenges of innovation, we are also frequently thrust into the complex relationship between ethical surgery and the pharmaceutical and instrumentation industries.

Needless to say, because of the many things that we have to offer and the need to be concerned with our own long-term financial security in the face of reimbursement and legal challenges, we must walk the narrow line between

providing the best care possible for all of our patients and complying with our own personal needs and those of our families. Claude Organ explained that, "So much of our orientation today serves to erode or spirit as caregivers". He goes on to say that surgery is under increased public surveillance; and we are consumed by endless paperwork, administrative hassles, ponderous bureaucracy, professional liability concerns, inadequate reimbursement for our work, limited access for our patients, an impersonalized system, and increasingly burdensome documentation. He cites the increasing federal mandates of the Health Insurance Portability and Accountability Act, the Emergency Medical Treatment and Active Labor Act, and the Program for Appropriate Technology in Health audits. He goes on to quote the highly respected surgical mentor, Haile Debas as saying, "professional status is not an inherent right but one granted by society.... This obligates surgeons to put their patients interests above their own."¹⁵

CATEGORIES OF PATIENT ENCOUNTERS

Severe Emergency: life in immediate jeopardy

An example would be a critically ill person brought in from a severe motor vehicle accident or one who has suffered a serious gunshot wound. Certainly there is no pre-established doctor-patient relationship, there is little chance that there will be a reliable surrogate, and many ethicists have questioned if a patient in such dire straits ever has *decision-making capacity*.

Urgent: serious problem needing surgery

An example would be a patient brought in with peritonitis. The individual may be in hypovolemic shock, is terrified, is in great pain, but is still cognizant of the situation and what is happening. There certainly is no pre-existing *doctor-patient relationship*, and no one is absolutely sure of the *decisional capacity*, especially if the patient disagrees with the recommendation of the surgical team. In a case such as this, where there is some but not much time, the presence of a *surrogate* and clearly described *advance directives* would be extremely helpful.

Semi-elective: will probably need surgery

An example would be an elderly patient with known extensive intra abdominal cancer who presents with a significant, unresolving intestinal obstruction. It is clear that the obstruction can only be relieved by surgery, but it isn't clear that this will be beneficial to the patient. In this case, determination of *decisional capacity*, the existence of *advance directives*, or the presence of a reliable

surrogate is very important; and there is enough time to pursue the intended desires of this patient.

AUTONOMY/DECISION-MAKING CAPACITY/COMPETENCY General Concepts

Autonomy vs. Paternalism: Trust is the Bridge

Individual freedom is one of the basic tenets of modern bioethics. This freedom is usually referred to as *autonomy*. This principle implies that a person should be free to make his or her own decisions. It is somewhat the antithesis of the medical profession's long practiced *paternalism* whereby the physician acted on what he or she thought was *good* for the patient, whether or not the patient agreed. The concept of *autonomy* applies to many interpersonal relationships, and is essentially a respect for each person as an individual

It has been difficult for many physicians, perhaps especially surgeons, to accept the principle of *patient autonomy*. This is not difficult to understand because accepting this principle implies a change in the physician's relationship with the patient. The physician must now be a partner in his or her patients' care; must become an educator, teaching uninformed patients enough about their diseases to make rational decisions; and most distressing, to allow autonomous patients to make foolish choices. For physicians dedicated to helping their patients, allowing them to select what the physician considers a terrible treatment option, or even refusing treatment altogether, is a very frustrating change.⁷

On the other hand, experienced surgeons know that their patients significantly rely on them for guidance through complicated choices, often where life itself is on the line. This is, of course, a form of *paternalism* which our patients request and to which they are entitled. The key to accomplishing, this ethically and successfully, is based on the principle of *trust*. For surgeons, the establishing of this trust must begin at the inception of the relationship, and sometimes must be very quickly accomplished. It is sometimes very difficult for our nonsurgical colleagues to understand and accept this element of *paternalism* required in the surgeon-patient relationship.

The crucial issue for the surgeon seeking autonomous informed consent is the *decision-making capacity* or *competence* of the patient involved. Understanding the differences between these terms is important, especially if the patient disagrees with the advice of the surgeon or refuses potentially life-sustaining treatment.

The determination of *decision-making capacity* involves more than just completing a mental status examination and includes the ability of the patient to

take in information, to evaluate a decision based on personal values, to make a decision, and to communicate the choice of decision to the physician. The concept of medical *decision-making capacity* is one based on the evaluation by the team providing medical and surgical care. This is distinguishable from a *legal determination of incompetence*. A patient is always assumed to be *legally competent* unless a *court* has declared otherwise. For example, patients may not have been declared incompetent by a court but may have lost the capacity to make decisions about their medical care because of their current medical status, including such conditions as intoxication, stroke, hypoxia, blood loss, dementia, or severe trauma. The determination of *decision-making capacity* varies in stringency with the seriousness of the impact of the decision. For example the more severe the risk posed by the patient's decision, the more stringent should be the standard of determining capacity. This provides an increased protection for patients of questionable capacity when the potential harm from their decision is greater. This reaches the pinnacle of importance when a patient refuses treatment for a potentially life-threatening condition. These decisions are often difficult to make in the emergency environment, and the treating surgeon must sometimes make practical ethical decisions that go beyond the basic law of informed consent.

Refusal of Treatment

Ethical dilemmas usually occur when there is disagreement among the patient, the family, and the healthcare team. The clearest example is a patient's refusal to accept the recommended treatment. This is especially critical for the patient who has *decision-making capacity* and refuses potentially life-sustaining treatment. The United States Supreme Court, in the *Cruzan case*, upheld the right of persons to refuse life-saving medical treatment, including resuscitation, ventilators, artificial nutrition and hydration, and life saving blood transfusions. The Court based its decision on "the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law under the *liberty interest*, protected by the Due Process clause of the Fourteenth Amendment of the Constitution." The Courts have, however, identified four *state interests* that override the refusal or termination of medical treatment on behalf of competent and incompetent persons, including the preservation of human life, the protection of the interests of innocent third persons, the prevention of suicide, and the maintenance of the integrity of the medical profession.

In exercising their rights under the autonomy principle, each competent patient has a right to refuse treatment, even if the results of such refusal will be their death. This type of situation is comes up most often in the case of religious

or cultural beliefs. Jehovah's Witnesses are probably the most familiar example of this type of dilemma. They refuse to accept blood transfusions, based on their religious beliefs. Such refusal, especially where major surgery is indicated, clearly poses the likelihood of avoidable death. Still, the competent patient's *autonomy must rule*. There may be situations where the treating surgeon feels that the competency of the patient refusing treatment may be in doubt. In such a case, if time permits, in order to protect the doctor and the hospital, it may be appropriate to go to court to get a court order permitting the indicated procedure or blood transfusion. The courts will weigh the possible benefits of the treatment against the potential negative effects, risks, and the potential burdens on the patient; and they will issue a ruling. This ruling will insulate the treating physician and the institution from legal liability. There are situations where parents or guardians are involved in refusal to accept and allow treatment on behalf of minors. These are the most common instances where court intervention is sought; and to resolve the problem the courts must balance the best interests of the child against the desires of the parents.

For sure, *refusal* of a life-sustaining medical treatment should be accompanied by a full assessment of *decision-making capacity* and by an understanding from the patient of the consequences of refusal. If uncertainty prevails, the surgeon on the firing line should still "err on the side of life".

Telling the Truth/Disclosing Errors

General Concepts

Physicians have a duty to tell the truth to their patients. This seems so obvious that it merits no further discussion. However, there may be circumstances where telling the *whole truth* to a patient will have a negative impact on his or her overall well being. If the physician believes that telling the patient everything about the condition in question, which is a duty, will have a dramatic negative effect on the patient's well being, the physician must decide which duty is more important in each particular situation.

Truth telling also would apply in situations involving *medical mistakes*, even those mistakes that are minor and arguably have no detrimental effect on the patient. To illustrate this point, let us consider a doctor awakened in the middle of the night who orders 1 mg of a drug, when the appropriate dose is 0.1 mg. The overdose has no detrimental effect on the patient, so does the doctor still have a duty to reveal the error that he made? Ostensibly, this question would seem to be easy to answer: just tell the truth! However, if informing a patient who's confidence in the medical profession is very low, and his mental stability might be diminished by finding out about a medical error, notwithstanding the fact that the

error had no detrimental effect, do doctors still have a duty to tell the truth? In this situation, it might violate the duty of nonmaleficence by doing something that will hurt the patient.

Prognosis: Balance between giving false hope and removing all hope

We are all involved in operations is desired outcomes are not met. Managing these patients through the entire course of their disease, and sometimes death, is an important part of being a good physician and surgeon. This becomes even more important as the population ages and we encounter older patients with multiple comorbidities. Especially in these older, high-risk, patients, even what is anticipated to be a fairly straightforward operation may have unexpected, adverse results. It forces us to remember the old adage that not everyone needs to die with an incision. Predicting prognosis, much less conveying it well to the patient and the family, is a difficult skill with little data to help us. We need to communicate with the public the fact that we would welcome the ability to accurately forecast outcomes especially for older patients, with higher risks, and in emergency situations. We truly can't distinguish which ones may actually do well from such high-risk operations. This necessitates us, as surgeons, to assume an important role in providing *palliative care* even when complete surgical *cure* is no longer a possibility.¹⁶

Discussing prognosis with our patients and their families is one of the situations, which forces us most carefully to choose our words precisely. Even when we are forced by patients and families to use specific statistics, we must use them in a manner that is helpful and not totally destructive of hope. It helps to explain that statistics are better for 100 people rather than for any given individual. It can be very expeditious for us to use statistics as a form of *truth dumping*; but such an act can be devastating to a terrified, desperate, and inadequately informed patient who is desperately clinging for any possible hope.

Patients with Impaired Decision-Making Capacity

Examples of patients having impaired decision-making capacity include minors, mentally handicapped persons, those with organic brain disease or in toxic states, and those with psychiatric conditions, including suicidal risk. Determining the point at which a minor has the capacity to make medical decisions is often very complicated and varies with the laws of an individual state.¹⁷ For example, an "emancipated" minor can make his or her own medical decisions. This includes individuals younger than the age of majority who are living on their own, are married, or are in the military.

Even patients with *Alzheimer's disease* cannot all be regarded as having lost their *decision-making capacity*. Depending on the severity of their disease, they may well be able to participate in much of the decision-making process. This of course depends on the status of their disease and on the complexity and implications of the decision to be made.

Suicidal Patients

Respect for autonomy has always had its limits. When treating a suicidal patient, the surgeon is faced with a conflict between the ethical principle of *beneficence* and *respect for autonomy*. Sorting out this dilemma is usually based on whether the suicidal patient is currently capable of making a rational, autonomous decision. It also raises the perplexing question: "can suicide sometimes be a rational choice?" Generally, surgeons intervene with the suicidal patient based on the assumption that the person is suffering from mental illness and impaired judgment. This assumption is usually correct, with 90% of suicides being found to be associated with mental illness such as depression, substance abuse, or psychosis.¹⁸

Therefore, relying on the principle of beneficence, surgeons almost always treat the injuries inflicted by suicidal patients despite their expressed intention to die. The conflict arises when the reasons for suicide appear "good", such as in the case of the terminally ill cancer patient with severe, uncontrollable pain. Is the application of lifesaving intervention truly a beneficent act in the patient's best interest? Several studies have shown that physicians rendering care in the emergency department are not likely to recognize treatable depression in their patients. These studies go on to confirm that 80% of patients who attempted suicide subsequently show that they do not continue to wish to die. Thus, although some patients might make a rational decision to commit suicide, in most cases the surgeon delivering care must assume that the person's judgment is impaired; and proceed with full indicated, lifesaving measures.¹⁸

ADVANCE DIRECTIVES

General Principles: Talking About Death

Facility in routinely addressing end-of-life issues with surgical patients is critical because it allows the surgeon to raise difficult questions with patients during the earlier phases of their disease process. Often the issues that are most difficult to address when patients near the end-of-life are those that have not been attended to earlier in the patient's course of treatment. Such early discussion allows the surgeon and the patient to discuss limits on treatment at a time when the patient is able to participate in the process. Usually, we surgeons are intent on

cure; and the prospect for death after most of our routine procedures seems very remote. However, these discussions are more important than ever because we now have more options available to prolong life than existed just a few decades ago. In addition, social changes have led to greater participation by patients in the medical decision-making process. With the increasing mobility of our society and the changing allocation of primary care physicians, we as surgeons often don't have the backup of a well-established physician-patient relationship. Add to this the very visible rise in public debate over *euthanasia* and *physician-assisted suicide* and we can understand the concern the public has over perceived, or actual, deficiencies in how patients are managed at the end-of-life.¹⁹

When a patient does not have the decision-making capacity to give informed consent, or there is no time to ask the patient or his or her surrogate about treatment preferences, *advance directives* express in written form what the patient's choices would have been if he or she had decision-making capacity. Advance directives include living wills, durable powers of attorneys, and other written documents. In 1991, the federal government passed the Patient Self-determination Act (PSDA), which required that healthcare institutions advise and educate patients regarding advance directives. This affected all institutions participating in the Medicare and Medicaid programs. This law was supposed to increase the use of advanced directives and thus prevent unwanted care. In fact a major study of advanced directives and seriously ill patients revealed that the PSDA had little impact on healthcare in the United States. This was revealed in the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), which showed that only 20% of seriously ill patients had advance directives even after the SUPPORT intervention and the PSDA.²⁰

Despite these studies, it is still imperative for surgeons to understand the principles involved and the advantages of advocating for appropriate advance directives for our patients and their families. An *advanced directive* is any proactive document stating the patient's wishes in various situations, should they be unable to state their own wishes.

Some states have specific language for each of these documents and provide reciprocity for other states. Both the *living will* and a *durable power of attorney* can be prepared without the benefit of state approved language as long as the intention of the person executing the document is clear. Such directives provide advanced informed consent for a myriad of courses of treatment, whether it be related to pain medication, "do not resuscitate orders", or management should the individual enter some level of persistent vegetative state. In a complete set of these documents, the patient has given full thought to all of the possibilities that might occur, and has decided what course of treatment would be his or her choice.

Unfortunately, most patients have not executed these documents, or they have not given sufficient thought to what their wishes are. Furthermore, many times when a power of attorney is granted to a surrogate decision maker, the surrogate has not had a full discussion of the wishes of the signatory.

Living Will

The *living will*, which was adopted by many states in 1990, is a document suitable for *terminally ill patients* where the treating physician accepts the patient's wishes regarding withholding of care, including requests restricting heroic resuscitative efforts, in advance. Many state that no life-support be used in cases where meaningful recovery will not occur. In a *living will*, the signatory indicates what his or her choices would be for medical treatment in the situation where *death is imminent*, and the individual's wishes are unable to be communicated to the treating physician. Under most state laws *living wills* indicate the signatory's desire to die a natural death and indicate unwillingness to be kept alive by so-called "heroic measures". This usually amounts to a "Do Not Resuscitate" order. In some states, that also indicates the patient's wishes concerning the level of pain medication, hydration, and nutrition, which the patient would desire if, he or she lapses into a non-decisional condition. In most states, the activation of the terms of a living will require an *imminent demise* and a second physician's opinion corroborating that determination. Unfortunately, many people believe that the *living will* is the best form of advanced directive and don't realize that it is only intended for the *terminally ill*.

Durable Power of Attorney

A *durable power of attorney for healthcare* specifies a surrogate decision maker in the event that the patient no longer has the capacity to make medical decisions. The *durable power of attorney* is a written document that gives the authority to another person, usually a spouse or relative, to make decisions regarding healthcare if the patient is incapacitated and unable to make decisions for himself or herself. The reason it is called "durable" is to ensure that the signatory knows that it can be revoked and or changed at any time. This provides the freedom to change both who the surrogate is and what the patient's stated wishes, if any, are. This is important in situations such as divorce were the person executing the power of attorney may want to change the surrogate before the divorce becomes final or in those family situations where dynamics create a desire to change the surrogate.

Thus, the patient designates a *surrogate decision maker* who should participate in all significant treatment decisions and be kept up-to-date regarding

the patient's healthcare. The *durable power of attorney* works best when the patient has discussed with a surrogate his or her values and beliefs, as these would apply in making complex decisions regarding healthcare issues. If there is no durable power of attorney, surrogate decision makers may be sought based on state laws. There is usually a defined hierarchy regarding surrogate decision makers: spouses, adult children, siblings, and so forth. Such a surrogate decision maker must be acting in the best interest of and according to the wishes and values of the patient. The *durable power of attorney* is a better form of advanced directive than the *living will* because, in the former, a surrogate can be educated about the nuances and options regarding each stage of treatment or non-treatment.²⁰

Problems

In many situations the surrogate has the legal authority to make a decision, but is not aware of what the patient would want. This is the fault of the patient. All persons, when naming a surrogate decision maker, have a responsibility to fully explain what they would want in certain medical treatment situations. Failure to do so puts the burden on the surrogate to speculate what the patient would do were they able to make the decision.

There are two standards that apply in the situation where the surrogate has not been informed of the patient's wishes. One is the *substitute judgment* standard. When using this standard, the surrogate bases a decision on a prior expressed statement of the patient's preferences or on an in-depth knowledge of the personality of the patient and a willingness to do what the surrogate believes the patient, not the surrogate, would want in that specific situation. The second standard is that of the *best interest* of the patient. This is obviously a far more nebulous concept and occurs where the surrogate has not had any specific communication with the patient about the specific type of situation and is not cognizant of any particular patient preferences. In this situation the surrogate is supposed to do what he believes is in the best interest of the patient. This is an important distinction to make and emphasizes the difference between doing what the patient would want done in a given situation, as opposed to having someone else decide what he or she thinks is best.

A further problem with advanced directives that limit full implementation of medical care is the application of such directives in situations for which they were not intended. An example that confronts the colon and rectal surgeon is an elderly patient who is recovering from a complicated colon resection for curable cancer and develops post-operative pneumonia requiring presumed short term ventilating support. Should such a patient not be intubated because of an advanced directive

indicating, "do not resuscitate"? In such a case, it would be a serious error to respect the advanced directive and not to treat the patient aggressively. It is clearly probable that the patient would have wanted treatment under these circumstances. (Type: see note p. 39. Use a case of pneumonia post op for a curable cancer + transient need to be put on a respirator)

There must also never be confusion when the patient is able to relate his or her preferences to healthcare providers. *Verbal communication takes precedence over any written advanced directive.* In addition, when there is any confusion about the advanced directive, disagreement among family members, or concern that it was not meant for the clinical circumstance at hand, *advanced directives limiting treatment should be ignored in favor of prudent medical care.* In general, it is always wise for healthcare providers to err on the side of life and to begin standard medical treatment. Treatment options, such as mechanical ventilation and hemodynamic support, can always be withdrawn at a later time once issues are resolved and the family is present. In such situations the hospital *ethics consultation service* can often prove very helpful.

Perhaps the major problem, at this point in time, is that there is little evidence that advanced directives have made a significant impact on healthcare delivery in the United States.²⁰ We, as surgeons, should do all within our power to reverse this situation.

INFORMED CONSENT

General Concepts

Studies have revealed that doctors do not adequately inform patients, patients may not understand the information, and such information rarely affects the patient's decision to follow the physician's recommendations. Despite these facts, American courts have long held that a patient's *informed consent* to a medical or surgical procedure or test is *essential*. The physician must give the patient sufficient information to make an intelligent decision before any action is performed. The laws dealing with informed consent require the surgeon to describe to the patient the nature of the procedure, risks, benefits, and alternatives, including no treatment at all. Ethical consensus on just how much disclosure is adequate is still very controversial. What is clear is that permission must be given *voluntarily*, that is, *without coercion* from the physician or anyone else involved in rendering healthcare or, especially, those participating in the implementation of a *research* project.

The current interpretation of the law requires several elements to constitute *informed consent*. These are the *criteria* that the physician must disseminate to the patient or acting surrogate to meet that standard:

a. What is the treatment that the doctor wishes to pursue, including a full explanation of the procedure and what it involves, including the necessity for anesthesia and other support functions?

b. For what reason has the doctor selected this particular treatment, including the doctor's judgment as to why this procedure is chosen to alleviate, cure, or minimize the medical/surgical problem?

c. What are the risks of the recommended treatment, including an explanation of both the risks of the treatment itself and of any corollary threats to the patient? Surgeons should, in satisfying this requirement, include discussion of their own particular *experience with the procedure* as well as that of the hospital and the medical/surgical colleagues who will be assisting.

d. What benefits will the patient receive from the proposed treatment? This is similar to the choice of treatment information previously described in that it requires the doctor to explain what the potential benefits will be from the procedure.

e. What are the chances that the proposed treatment will remedy the problem? This is similar to the information included when describing "benefits and risks" and should also include a description of the *past experience* of the surgeon in performing this specific procedure, as well as the *outcomes* that the surgeon has obtained.

f. What alternative treatment options exist for the given problem? This is similar to explaining the choice of treatment but emphasizes what other treatment options are available, and why this surgeon has chosen this particular procedure.

g. What effect will refusal to accept the proposed treatment have on the patient? This must entail a frank discussion of the ramifications of failure to receive the suggested treatment and whether it is life threatening, or of a lesser degree of medical difficulty. This is the part of the discussion where the surgeon must be most sensitive to the patient's religious, cultural, and ethnic background.

Here the law requires that the sufficiency of the level of information will be judged from the *patient's point of view*, not the doctor's. If a surgeon explains a proposed treatment to the patient in terms that only another surgeon can understand, then the patient is not truly *informed*. This simply boils down to communication skills and the obligation to accurately *record* this discussion in the medical chart prior to performing the recommended surgical treatment. Every profession has its own terms of art or jargon. Physicians must strive to ensure that the language they use is clearly understandable. Achieving acceptable levels of communication may be complicated by language, cultural, and socioeconomic factors. A manager responsible for building a new jetliner was credited with saying, "The main problem with communication is the illusion that it has actually

occurred". All too frequently patients and families come away from discussions with surgeons where the surgeon thinks he has effectively communicated, and the patient and family seemed to understand, but they didn't. Sometimes it just boils down to faith in the doctor, or an individual's unwillingness to reveal his or her lack of comprehension. The physician must use *common sense* in determining whether fully informed consent has truly been granted, taking into account that some cynics claim, "The problem about common sense is that it is not common".

As with every rule of law, there are certain *exceptions* to the requirement for informed consent. When there is an emergency situation that could result in the death of the patient, time is of the essence, and there is no surrogate decision maker present, the *consent requirement is waived*. Similarly, when the situation is not an emergency, but the patient is for one reason or another not able to give consent due to unconsciousness, coma, mental disability, or other cause of inadequate decision-making capacity; and there is no advance directive nor surrogate, informed consent is not necessary. There is also a *therapeutic exception* to the rule. If the physician believes that revelation of the normally required information would have a negative effect on the patient's health, fully informed consent is not necessary. This usually arises in the context of a psychiatric patient. Also, when a competent patient *refuses* to receive information upon which to base a decision, this requirement is waived. There can also be a waiver of the necessity for informed consent when the *government* requires certain medical tests or treatment in the face of possible medical or national security emergencies.

A common misconception among those rendering emergency care is that anyone who presents to an emergency facility falls into the *emergency exception* to informed consent. The *emergency exception* allows a physician to treat a patient without obtaining informed consent. This exception requires the following: the patient must be unconscious or without the capacity to make a decision, and no one else legally authorized to make such a decision is available; time must be of the essence in avoiding risk of serious bodily injury or death; and, under the circumstances the action proposed would be that to which a *reasonable person* would consent. The emergency exception does not apply if the patient has decision-making capacity and is able to communicate a decision about medical care.²

Patient-Surgeon Relationship

Siegler explains that the three central ethical aspects of modern surgical practice are (1) clinical competence, (2) respect for patients and their healthcare decisions, (3) maintaining the primacy of the patient's needs in the face of external pressures in a changing social, economic, and political climate. Successful

clinical practice has always been a unique blend of technical proficiency and ethical sensitivity, which together constitute the art of the physician and surgeon. Once sought out by the patient, the surgeon becomes involved in the patient's problem. He or she is no longer a mere observer. Over the last few decades, the relationship between patients and physicians has been evolving from one of *paternalism*, in which surgeons may choices for their patients, to a more equal and *autonomous* relationship of shared decision making by which surgeons provide information that allows competent adult patients to make their own choices.²¹ For complicated surgical dilemmas, this can never evolve completely because patients depend on the surgeon and their other physicians to guide them to the correct choice.

Sometimes surgical procedures considered "standard of care" by the surgeon are refused based on the patient's values and beliefs. Such cultural challenges can affect the success of the patient-surgeon relationship and ultimately the health outcome for the patient. Ultimately the surgeon must learn to take into account the cultural components of the relationship and find ways to respond to them in an ethically and medically responsible manner. In order to deal with these complicated situations, the surgeon is often required to reassess and be secure in his or her own religious and cultural foundations.²²

As Peter Angelos explains, the relationships that individual patients have with their surgeons are as varied as are the different types of surgical problems with which patients present. Perhaps patients are required to have a great deal of trust in their surgeons because of the nature of surgical intervention itself. This may result in patients frequently feeling a deeper personal bond with their surgeon than with many other physicians who may be involved in their care. Surgeons as well as their patients, frequently feel the closeness of this bond. Angelos quotes Charles Bosk as explaining:

"The specific nature of surgical treatment links the action of the physician and the response of the patient more intimately than in other areas of medicine... When the patient of an internist dies, the natural question his colleagues ask is, "what happened?" When the patient have a surgeon dies his colleagues ask, "What did you do?"

When patients consider the surgeon to be "their doctor", the surgeon must not ever underestimate the importance of maintaining this relationship even, or perhaps especially, as the patient approaches the end-of-life. The impact of a concerned surgeon on a patient who is dying, or is curable, can serve to dramatically affirm the appropriateness of comfort care instead of desperate, ineffective, and costly attempts to ward off death.¹⁹

Communication and the Internet

It seems so easy to be able to respond to a patient's problem or to deliver information to them and their physicians by e-mail. With e-mail delivered via the Internet, there is no problem with timing of the conversation, no recordings, no time on "hold" for the doctor or for the patient. The only limitation seems to be the typing and spelling skills of the surgeon, usually problem enough.

Most of us have learned not to deliver complicated or bad News by telephone, unless we have made a previous agreement with the patient and family to convey such information in order to save significant travel or other inconveniences that are significant enough to preclude a face-to-face personal communication. Such situations are now increasingly complicated because communication by the Internet is usually not secure, and the information delivered can become a permanent part of the patient's record. A patient's employer and family can usually acquire easy access to the electronic message, potentially to the detriment of the patient, and potentially leaving this sending physician legally liable.

For the medical and medical legal aspect, some of the material we send by e-mail we would never consider sending by "hard copy" unless we had obtained the patient's specific permission to release such information. Currently, there are no guidelines available for the ethical transfer of confidential medical information via the Internet. Until such exists, and it is critical for physicians to participate in the establishment of such principles, all doctors are probably well advised to record in the patient's permanent record that discussions were held and permission was given to communicate specific information electronically. Especially with the implementation of HIPAA requirements, until clearer guidelines are defined, surgeons should err on the side of no sensitive information to be delivered by e-mail or telephone.¹⁹

Of course, the other massive impact of the Internet is the availability of unlimited access to potentially confusing and harmful information to our patients. Remember, there is no quality control for the Internet. Unlike traditional publications with editors, peer-review, standard's and vigorous screening, on the Internet, anyone with a computer can be a self designated author, editor, and publisher. And, this can be done anonymously with no attached responsibility. This will continue to have an enormous impact on the patient physician relationship because "knowledge is power"; and our patients and families are making use of that power.²³ Not infrequently patients come to us with confusing and conflicting material from the Internet. A new part of our responsibility, as surgeons, is to not only guide our patients to appropriate and helpful web sites but to actively

participate in the construction and quality control of electronic information provided by the Internet in our own areas of expertise.

Using Newly Deceased Patients for Teaching Purposes

A unique problem exists for the medical/surgical team caring for patients in the emergency department of a teaching hospital. It involves using the newly dead for teaching purposes. This most commonly involves teaching medical students and residents the techniques of endotracheal intubation. The issue is, of course: do we have the right to perform procedures on this newly deceased person without obtaining permission (informed consent) from the surviving family. The dilemma is complicated by the fact that no better teaching opportunity exists for our trainees who can then go forward, when adequately trained, to save lives and relieve suffering in the future. Clearly, no harm can be done to one who is dead. Further, to our knowledge, there are no state statutes that specifically prohibit the teaching of procedures using newly dead patients; and no court has considered this issue. Although, before death a patient has constitutional protection against nonconsensual invasion of his or her body, it has been established by various state courts that constitutional rights do terminate at the time of death.

Although the law in this situation is very forgiving, compassionate and ethical considerations should supervene. Several medical studies have found that patients and families are likely to consent to such procedures but prefer to be asked permission first. Even the law advises that in this day and age of increasing recognition of personal autonomy, it is probably prudent to approach the next of kin for permission before performing procedures on the newly deceased.²⁴

Special Concerns for Participation in Research/Innovation

General Concepts

Surgeons, by our very nature, are innovators. Sometimes, the only way we can complete an operative procedure is by making a deviation from what has been standard procedure in the past. Since we operate on biological systems, we can never predict exactly what will be required for a given procedure. We often use old procedures for new purposes, and without much hesitation use new equipment to accomplish old tasks. Thus we often find ourselves in what McKneally refers to as "the zone of innovation" where it is unclear whether what we are doing is an evolutionary variation on a standard procedure, a unique departure from accepted standards, or the first stage of what should become recognized as a formal surgical research project.²⁵ When should our deviations be subjected to full evaluation by an Institutional Review Board? How can a surgeon participate, with *equipoise* (the presumption that both arms of a study are equally efficacious) in a

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prospective randomized trial to evaluate a change that the surgeon has created to be better than the known standard? As Martin McKneally explains, most of the important advances in the history of medicine, such as anesthesia, appendectomy, antibiotics, intensive care, and immunization, were introduced through an informal, unregulated innovative process that has been enormously productive but can easily lead to ratification of an effective or even harmful treatment by well-intended physicians.²⁵

Look at the recent challenges facing colon and rectal surgeons. We adopted the construction of ileal and now colonic pouches to improve the quality of life of our patients with inflammatory bowel disease and rectal cancer. The true efficacy of these innovations came significantly later than their description and implementation by many of our colleagues. The use of minimally invasive techniques to accomplish what we were all trained to do via abdominal incisions was clearly initially driven by the new technology and by enthusiastic entrepreneurs who wanted to work on the frontier of innovation. The premature exposure of these new techniques to the lay literature drove the process with even more intensity. Only recently have completed prospectively randomized trials verified the realistic advantages of the new technology. We continue to sort out the appropriate use, for the benefit of our patients and their quality-of-life, such issues as circular stapled hemorrhoidectomy, the treatment of anal fissures with nitroglycerin, botulinum toxin, or nifedipine, and even the destructive scarification of anal tissue to correct incontinence. What we need is a process for evaluation of surgical innovation, which provides ethical oversight without the ponderous slow pace inherent in most IRB approved protocols. Surgical investigators and ethicists are currently crafting such a mechanism, which protects the rights and well-being of our patients without stifling progress and creativity.

Good research is described as that which enhances our ability to prevent illness or injury, to improve the quality or decrease the cost of care, or to improve the lives of our patients. Such research also must protect subjects and patients from harm, preserve their confidentiality, and allow them to enter freely as participants. Subjects and patients must be allowed to make an informed choice to participate, or not, without fear that their treatment might be compromised if they decline the request of the investigator. For a research project to be ethical, it must also be well designed and must investigate an issue of importance for which the answer does not yet exist. Protocols must be scientifically sound and likely to yield meaningful conclusions. Good research is therefore ethical, and bad research is unethical.²⁶

In June 1966, Henry Beecher published an analysis of "Ethics and Clinical Research".²⁷ This benchmark article accelerated the movement that brought human experimentation under rigorous federal and institutional control. Although Beecher was not the first to direct attention to abuses in human experimentation, this presentation of 22 examples of investigators who endangered "the health or the life of their subjects" without informing them of the risks or obtaining their permission was a critical element in reshaping the ideas and practices governing human experimentation.²⁸

Special issues for informed consent arise when the surgical patient is asked to participate in a *research project*. The time for decision-making is usually short, and the principle investigator of the project may also be the one administering care. This raises not only the issue of adequate informed consent but of the *risk for coercion* of the patient to participate in the study. The surgeon researcher should abide by basic principles as outlined by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and by the Declaration of Helsinki. There are also prevailing federal, institutional, and professional guidelines that govern human and animal research. To be ethical, studies must be well designed and worth the risk to patient and society. The institution's review board should approve the study, and the investigator should take the responsibility to assure adequate informed consent, confidentiality, and appropriate protection of the patient's well being.¹

All physicians must ensure that trials involving human subjects are of potentially significant value and are conducted ethically. The Nuremberg Code obligates researchers to prepare descriptions of the probability and magnitude of all physical, psychological, social, and economic risks, and to minimize unnecessary pain and suffering. Consent must be voluntary and without any element of force, coercion, or deceit.¹¹ When discussing the potential risks of a proposed procedure, it is essential for the person seeking consent to quantify minimal, low, or high-risk using examples from everyday life. Potential benefits from a research project may apply to the individual, to society, or to both. When discussing the benefits of a proposed study, one must distinguish clearly between therapeutic and non-therapeutic research. Researchers must clearly differentiate, for the patient, the balance between *potential benefit* to the patient and any *potential risks* associated with the protocol. No matter how great the benefit to society, it would not be ethical to expose a subject to anything greater than minimal risk if there is little direct benefit to the patient.²⁶

Consent must never be assumed. Many would question the validity of truly "informed" consent rendered by someone who is acutely ill or severely injured.

Especially for research, the principle still holds that for consent to be valid, it must be informed, understood, and voluntarily given. Subjects, or their surrogates, must have enough information, in comprehensible form, to enable them to make a proper judgment as to whether or not to participate in the requested study. Normally, this requires time for reflection before a decision to enroll. This concept is frequently stressed in the emergency situation. In an emergency, the surgeon may be forced to act in the patient's best interests and to presume consent on the basis of necessity. Clearly, this is only appropriate for interventions that will benefit the patient directly; and actual consent should be obtained as soon as possible afterwards. In a research context, the intervention must be part of a protocol approved by an independent institutional committee, such as an IRB, and should present no more than minimal risk to the patient.²⁶

Placebo Surgery

As investigators sort out the mechanism for insuring that surgical research is carried out ethically and with true *informed consent*, the issue of the use of *placebo surgery* appears based on recently published trials. Horng and Miller, commenting on these trials in the *New England Journal of Medicine*, comment that the issue of using *placebo surgery* in clinical trials appears to violate the fundamental ethical principles of *beneficence* and *nonmaleficence*. Specifically, this means that surgeons should not invade the body except for purposes of cure or amelioration of suffering. In evaluating the studies, they emphasize the fact that clinical research always involves the inherent tension between the ethical values of pursuing science and those of protecting subjects from harm. To be considered ethical, overall, they must present a favorable risk-benefit ratio. The burden is on the investigators to justify *placebo surgery* as a warranted means of evaluating the efficacy of a surgical procedure. They conclude that absolute prohibition of *placebo surgery* is not appropriate, but the standard of justification for its use must be extremely high and rigorously enforced.²⁹

Conflict of Interest: Industry and Drug Money

Many colon and rectal surgeons interested in research have difficulty obtaining extramural support for their projects and thus turn to private sources, namely the biomedical and pharmaceutical industry. Industry support for biomedical research now exceeds the financial support from all federal funding sources. The liaison between academic surgery and industry introduces the possibility of remarkable benefits especially to our patients; however differences between the fundamental goals of physicians and industry can create serious conflicts. Industry strives to complete clinical trials expeditiously and to publish

positive results. Conversely, the primary goal of the surgical investigator is to advance and disseminate knowledge by the unimpeded exchange of ideas, despite secondary professional, financial, institutional, and sociopolitical objectives. Critics maintain that the physician-industry relationship will only serve to potentiate bias; and loss of objectivity will fundamentally poison the way research is conducted. Currently, however, the lifeblood of clinical research is external support requiring a productive relationship with the biomedical industry. This potential conflict of interest can only be resolved by scrupulously implementing the principles of integrity, honesty, respect, and equity. Even the mere appearance of a conflict of interest could jeopardize the investigator's integrity and undermine public trust. Surgeon investigators involved with industry-sponsored research should meticulously divorce themselves from any personal or commercial conflict that could compromise patient loyalty or well-being.¹¹ Ethical recruitment of patients into research protocols is especially challenging for surgeons who, under the current system of financial remuneration, may receive more money by having the patient participate in a study than he/she would receive for doing the surgical procedure indicated for the patient.

A common challenge involves investigators who receive industry-funded materials, discretionary funds, research equipment, and trips to meetings. They must be aware that subsequent restrictions and expectations can create conflicts of interest. These seemingly innocent economic factors become a conflict anytime they influence study design, interpretation of results, or the timing and method by which results are reported. The personal gain of the investigator such as ownership of stock or receipt of funds for testing drugs or devices can introduce bias and compromise objectivity. On the other hand, it is not inappropriate for an investigator to receive economic rewards from a drug or device that is commensurate with his or her efforts involved in the development of the product. It is also acceptable for investigators to receive consultant and lecture fees from companies whose product they are testing, provided that the remuneration is proportionate with his or her efforts, and that it is clearly reported, in advance, of all presentations and is clearly stipulated in any publications. It is unethical, however, to sell or purchase stock or have a direct financial interest in the product under investigation until the relationship between the investigator and the company has been terminated, and the results of the research have been published or made public. Although opponents argue that disclosure cannot heal the financial conflicts of interest, it does recognize public concerns, protect the credibility and reputation of investigators, and alerts readers as they access the published report.¹¹

The practice of pharmaceutical companies bestowing gifts on physicians is well documented. These gifts, however, cost money; and that cost is ultimately passed on to our patients without their explicit knowledge. The biomedical industry has clearly made outstanding contributions toward the advancement of modern scientific medicine; however, obvious conflict of interest occurs when physicians accept personal gifts that have no benefit to their patients. Acceptance of individual gifts, that did not benefit patients, such as trips and subsidies for medical educational conferences in which physicians are not speakers, are strongly discouraged. The acceptance of even small gifts has been shown to affect clinical judgment and to heighten the perception (or reality) of a *conflict of interest*. Until specific guidelines are established, commonsense should always prevail: no gifts should be accepted if suspected *strings are attached*.¹¹

CONFIDENTIALITY

General Principles

Surgeons are bound by the same rules of *confidentiality* as other doctors. Especially with the new restrictions and significant penalties imposed by HIPAA, all healthcare personnel must be very cognizant of preserving *confidentiality*. In the hectic morass, which is the waiting area of most big hospitals, it is sometimes difficult to take the time to ensure that doctors convey sensitive and private information to patients, families, or surrogates in a full and complete manner, and yet ensure the confidentiality of their information. Certain health information can be very significant in the treatment of a patient, including medication history and psychiatric history. Yet, some patients or families might be reluctant to give such information to the treating physician if the situation is not conducive to confidential communication. Similarly, the families and the patient are most certainly due confidentiality of the information, which the physician is going to impart. It is critical for the surgeon to establish a trusting relationship; so that the best and most important information relevant to treatment can be given and received. An exception to this rule occurs when the law requires disclosure of information to officials, as in the case of certain infectious diseases or in situations where a third-party might be injured as a direct result of the physician's failure to report information.

A surgeon's duty to maintain confidentiality regarding information disclosed by the patient has been a long-held medical precept. On occasion, however, the ethical duty to prevent harm to others overrides the duty to keep confidences of a given patient. Although the law generally prevents the divulgence of confidential information, it also *mandates certain exceptions*, such as reporting patients with infectious disease and those who are likely to harm others, the latter being elucidated by the famous 1976 Tarasoff case in which nondisclosure of a patient's

homicidal thoughts resulted in the death of the threatened person. This case raises a confusing possibility of preventing harm to others becoming a legal not just an ethical duty. This broadens the concept of mandatory reporting to include more than the currently accepted requirements for reporting child, elder, or domestic abuse. Such legal requirements may force us to compromise the ethical norm of respecting our patient's decisions with regard to confidentiality.²

Making and Managing a Genetic Diagnosis

As the results of untangling the mystery of the human genome are translated into clinical considerations, the ethical challenges to the colon and rectal surgeon to become significant. Although the presumption is that facility and managing genetically predetermined disease is the lot of the primary care physician, in fact, patients with phenotypic presentation of genetic disease is such as colon and rectal cancer depend on surgeons for final diagnosis, administration of surgical treatment, initiation of long-term follow-up, and clarification of the implications of the genetically predetermined cancer for other family members and other generations. Most commonly we deal with the autosomal dominant mutations, which cause familial polyposis or hereditary non-polyposis colorectal cancers.

The ethical hazard involves obtaining the results of a genetic test without adequate counseling of the patient to determine what will be done with results was obtained. Clearly, this should all be determined prior to obtaining the information. Many individuals fear that determination of a genetic abnormality will have adverse effect on their insurability and employability. These risks are supposed to be protected by law, but many members of our society are not willing to take that chance. Because of these fears, many patients and their family members refuse to have genetic testing done in the first place. Once the test is done, a patient may insist on absolute confidentiality to prevent dissemination of the information to others, even those at risk, in the family. Think of the dilemma in which this places the surgeon. You may know that 50% of children and siblings of the patient are at risk for potentially fatal cancer. Yet the patient has forbidden you to inform them. This situation can even ethically and illegally justify the physician breaching the patient's confidentiality to save the lives of those potentially at risk. There have even been cases in the courts where the treating physician has been held liable for **not** divulging such risks to family members.

Most of these unpleasant situations can be avoided by appropriate genetic counseling before any genetic information is required. This should ideally involve the use of professional genetics counselors since most of us surgeons have not been adequately trained in the skills required.

Abuse of the Elderly

It is claimed that approximately 2 million elderly Americans are mistreated each year, with a significant number falling into the definition of abandonment. Although this treatment of elders is a problem that has occurred for centuries, only recently has society become significantly concerned. The problem and concern will increase as does the elderly components of our population. Surgeons are ideally suited to play a significant role in the detection, management, and prevention of elder abuse and neglect. The surgeon may be the only person, outside the family, who sees the older adult and is qualified to intervene in a preventive way. This means we should be aware of risk factors and their detection. It requires an astute clinician to detect abuse based on history alone. Even in the face of injuries, such as fractures at uncommon sites, the elderly patient may continue to conceal the possibility of abuse for fear of embarrassment or abandonment by the abuser. It may well be the surgeon called to see the patient for injury or neglect, who picks up the clues such as evidence of pressure sores, malnutrition, old injuries, or new injuries in unusual locations, such as on the scalp or behind the ears.

The first priority of the physician is to ensure this victim's safety. The surgeon should never hesitate to ask for social service consultation or to report suspicions to the appropriate adult protective services. Such acts are not breaches of confidentiality; they represent implementation of the most sincere duty of the physician.³⁰

FUTILITY/WITHHOLDING TREATMENT

General Concepts

Significant, and perhaps inappropriate, concern continues to exist in medicine with regard to the difference between *withholding* and *withdrawing* medical treatment. This has become more of an issue as the potential for resuscitating critically ill patients has become a progressive reality. Depending on the clinical situation, surgeons and other physicians attribute higher legal risk of one procedure over another. Apparently because of this fear of legal retribution, or ridicule and condemnation by professional peers, employing full, almost ritualistic, resuscitation has become the default position of those delivering critical care in cases where no advanced directive exists. In fact, no physician has ever been successfully prosecuted for withholding or withdrawing of medical care from any dying patient in the legal history of the United States. This leaves one wondering what actually fuels the fears of legal retribution for making the wrong decision.³¹

The dilemma could of course be alleviated by early meaningful discussion with patients, families, and surrogates with regard to care *options at the end of life* and honest estimates of *prognosis*. Studies have shown, however, that many physicians and surgeons fail to take these opportunities. A disturbing example of this inadequacy can be found in the 1995 Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT). This expensive, multi institutional study demonstrated the physicians' *failure to meet all outcome markers*: failure to include patient and family in pivotal care discussions, failure to provide realistic estimates of outcomes valued by patients, failure to treat pain adequately, and failure to prevent prolonged death in patients with extremely poor prognoses.³¹

Sometimes confusion is created over the venue in which surgical or medical care is delivered. In the usual setting, a decision to *withhold* further medical treatment is done quietly, often without input from the patient or the surrogate decision maker; whereas *withdrawal* of ongoing medical treatment can be more obvious and difficult. Some clinicians and ethicists feel that the *withholding* of medical treatment is more problematic than later *withdrawal* of unwanted or useless interventions. This discrepancy in the urgent situation probably exists because the physicians involved usually lack the vital information about their patients' identities, medical conditions, and expressed wishes. In addition, perhaps because of frequent, but inaccurate, representations on television, society has come to expect only spectacular results in the delivery of surgical care in the United States. This concept is in marked contrast to the attitude that those clinicians who *withdrew treatment* (an act leading to death) were more culpable than those who *withheld treatment* (an omission leading to death) this distinction between acts and omissions is now thought to be more of a difference in psychological preference than an ethical norm.³² For all of these reasons, despite the fact that the law has clearly spoken, the distinction between *withdrawal* and *withholding* of medical treatment will continue to be a challenge.

The surgeon's decision to limit or withhold treatment can be based either on the patient's refusal or on the physician's determination that the treatment would not be of benefit. Although the patient has the ethical and legal right to forego treatment, the physician must be very careful about withholding a treatment that might be beneficial. Such issues are usually intensified by the need for rapid intervention versus the desire to verify the meaning of the patient's current or pre-existing desires. The classic example is the patient who is unresponsive, has reversible pulmonary or cardiac disease, needs cardiopulmonary resuscitation, but is said to have a pre-existing DNR order (do not resuscitate).

Withholding treatment because of a judgment of *futility* is even more of an ethical challenge. *Futility* has been defined as "any effort to achieve a result as *possible*, but that reasoning or experience suggests is *highly improbable*, and cannot be systematically produced." Physicians, as moral agents, should exercise professional judgment in assessing patient's requests. If the request goes beyond well-established criteria of reasonableness, the surgeon ought not feel obliged to provide it. Some ethicists believe that the appropriate *allocation of resources* is another important consideration when one is making decisions regarding invasive, costly, or lengthy procedures. John Lantos even stated that, "given limited resources, it is ethically justifiable to limit access to treatments that are expensive and offer minimal benefit... decisions by doctors to curtail use of those treatments are socially responsible."³³ *Futility* is such a complicated word that it may be of little use in most situations. The classic challenge is the decision not to start resuscitation when a patient with extensive metastatic cancer and cachexia presents in cardiac arrest. The initial emotional inclination is to treat the patient, however the medical situation, as emphasized by Siegler,¹³ leads to a judgment that such a resuscitation will not be beneficial. This requires the difficult objective determination of *ineffectiveness*, rather than any subjective decision based on the worth of the intervention or on the *value* of the patient's continued life.² It should be noted that assertions of *futility* come about in two contradictory situations. One is where the patient or surrogate wants the doctor to refrain from a further treatment, which the doctor thinks, is not futile; and the other is where the doctor wishes to refrain from treatment which he or she believes to be futile. The only measure of what should be done is the standard of care in a given region for similar cases. Dealing with this concept of *futility* or other *end-of-life* concerns is usually only a problem when disagreement arises among the patient, the family, and the healthcare team.

Many ethicists agree that physicians are under no obligation to render treatments that they ascertain to be of little or no benefit to the patient. Many, however, believe that it would be advantageous to abandon the word "futility" and to use instead the construct of "clinically nonbeneficial interventions". We all know that one of the greatest fears of both patients and families is their *abandonment* by the healthcare team. It is easy to fall into this trap by declaring that further treatment for a given patient is *futile*. When it is decided that certain interventions should be appropriately withheld, special efforts should be made to maintain effective communication, comfort, support, and counseling for the patient, family, and friends. Although we, as surgeons, may not always proceed with potential technologically advanced nonbeneficial interventions, we always must continue to care for the patient and the family.³⁴

DNR and the Need for Surgery

There is, and should be, confusion regarding operating on a patient with existing "do not resuscitate" orders. Since there is no universal agreement as to how this situation is to be handled, each surgeon must be aware of specific institutional guidelines. First of all, it is not at all unusual for surgery to be indicated for patients where *cure* is no longer the goal of treatment. Even patients with advanced cancer or severe medical conditions will be offered surgical relief of acute intestinal obstruction or an abscess causing sepsis and pain. The problem usually gets defined when administering anesthesia becomes a consideration because, after all, it can be accurately stated that the act of anesthesia is *ongoing resuscitation*. As amazing as it seems, most hospitals have a policy, which allows suspension of the DNR order during the procedure and administration of anesthesia, only to have it resume when the surgery and required anesthesia have been concluded.

WITHDRAWAL OF TREATMENT

General Principles

Taking into account the preceding discussion, an important line of reasoning for the moral and legal equivalents for the two actions of *withholding* or *withdrawing* is the important concept that if a medical intervention will not result in the desired or beneficial results intended for the patient, it makes no difference whether the clinician withholds the intervention before beginning it or discontinues its use after it has been started and found to be not effective.³²

Special moral issues may arise in the care of *terminally ill patients*. We must be willing to respect a terminally ill patient's wish to forego life-prolonging treatment, as expressed in a living will or through a healthcare surrogate appointed via a durable power of attorney for healthcare. Those of us caring for patients should be willing to honor "do not resuscitate" orders appropriately executed on behalf of terminally ill patients. We should also understand the established criteria for the *determination of death* and should be prepared to assist families in decisions regarding the donation of the patient's organs for transplantation. This involves knowing the specific regulations in our own states and in our own specific institutions, especially the criteria for death and the mechanisms for initiating the conversation relative to organ donation. It is usually not the surgeon, nor any member of the treating team, who first raises the issue with family regarding donation of the dying patient's organs for the purpose of transplantation.

Euthanasia/Physician-Assisted Suicide/Terminal Sedation

The terminology of activities related to the end of life are confusing to the public, have been misused in the press relative to the notorious activities of individuals such as Dr. Kevorkian; and, in fact, are probably not clearly differentiated by many surgeons. The terms all have separate meanings and implications, requiring us to understand them and not use them interchangeably.

First is *euthanasia*, which literally means "good death". Its consideration arises when patients or surrogates claim that the quality of life is so diminished, the pain and suffering is so unbearable, or they have become such a burden on others that they request their physicians to cause their deaths quickly and painlessly. Specifically this implies "mercy killing" of an individual, by a physician, to relieve pain and suffering. Such terms as "voluntary", "nonvoluntary", and "involuntary" have been applied in an attempt to clarify the various ramifications of this process; but, in fact, *euthanasia* is the act of killing by a physician and is not legal anywhere in the United States.¹³

Physician-assisted suicide, on the other hand, implies a death that a competent person, with decision-making capacity, chooses and *causes* by self-administration of drugs that a physician has prescribed but *did not administer*. Advocates feel that prescription of drugs that a patient can take at will removes the physician from direct participation. The decision and the act of ending life remain in the patient's control. This invokes the important fall-back concept for physicians and nurses who deal with patients who are suffering, in an irreversible medical condition, and near the end of life: the distinction between "killing and allowing to die". This distinction is invoked during the process of *terminal sedation* as well as for participation in *physician-assisted suicide*. Currently, the latter is legal only in the state of Oregon.¹³ Even there, it has been complicated by the recent, and unique, intervention by the Federal government, via the Food and Drug Administration, to criminalize the act of over-prescribing pain medication by physicians where the act could be interpreted as intentionally facilitating a patient's death.

Terminal sedation, another frequently misunderstood term, is the practice of sedating a patient to unconsciousness in order to relieve the horrible symptoms, which may occur during the process of dying, including pain, shortness of breath, suffocation, seizures, and delirium. As the sedating medication is administered, other life-sustaining treatments are withdrawn, including ventilatory support, dialysis, artificial nutrition, and hydration. It is critically important to understand that in this frequently employed process, *no lethal doses of opiates or muscle relaxants are administered*. Thus, the intent of the act is to relieve suffering and symptoms by making people unconscious and unable to eat or drink, so that they will

die within a short period of time. As in *euthanasia*, *terminal sedation* directly intends the death of the patient.¹³ The difference is that, in the later, the sedating medication is not the agent of death. This differentiation is of utmost importance to avoid the feeling of killing by *double effect* (which will be later explained in more detail) on the part of the health care team. It invokes the concept of "letting nature take its course" as opposed to the homicidal act of "killing". Cynics claim they are the same, and those of us who claim otherwise are not being honest with ourselves.

Applying the Principles

In order to comply with the principal of *autonomy*, when a competent patient requests, or demands, the withdrawal of further treatment, the treating physician is in a situation analogous to that of the patient who initially refuses treatment. *Autonomy governs!* The surgeon should ensure that the patient is given all the information necessary to allow proper informed consent regarding withdrawal of treatment; but once that is done, it is the ethical duty of the surgeon to withdraw the specified treatment. This is true no matter what the patient requests, whether it be withdrawal of feeding tubes, ventilators, or nutrition and hydration. As long as the patient is fully aware of the consequences, both short-term and long-term, his or her stated wishes should be respected and acted upon appropriately by the healthcare team.

The same principal should be invoked if the patient is not able to understand but has provided, in an advanced directive, an indicated desire with respect to withdrawal of treatment under specified circumstances. It is still the duty of the physician to withdraw the specific treatment because the patient has, in the advance directive, given prior informed consent. The duty of the physician is identical if a designated surrogate requests or demands the withdrawal of treatment. This is the patient speaking through the surrogate, and once again, *autonomy governs*.

When the surgeon determines that withdrawal of treatment is appropriate and further treatment would be ineffective, consent of the family or surrogate should be sought. In this situation, it is very important and helpful to know what if any *surrogacy laws* exist. These do vary from state to state, and those surgeons faced with potential decision-making should know in advance the laws of their state. In states where such laws exist, they can be very helpful in delineating the hierarchy of surrogate designation. In the absence of advanced directives, surgeons have the responsibility to judge what they believe the patient would want, or what is in the best interest of the patient. If no family is available, close

friends of the patient may be asked to give their opinions about what the patient would want.

Courts have upheld the principles of *autonomy* and *self-determination*, affirming the right to refuse life-sustaining treatment. The classic illustrations of this include the 1976 ruling by the New Jersey Supreme Court that Karen Ann Quinlan, a woman in a persistent vegetative state, had the right to decide to be removed from a respirator and that this right could be asserted, on her behalf, by her family. This right was extended to include the withdrawal of nutrition by the 1990 Cruzan case in which the US Supreme Court ruled that a life-sustaining feeding tube could be removed from another young woman in a persistent vegetative state.¹⁸

Should the surgeon have moral or religious beliefs that would preclude her from *withdrawing* treatment, she should remove herself from the case. It is important to recognize this possibility of need for withdrawing treatment at the beginning of the clinical encounter because a physician with such beliefs should extricate herself from the case at the earliest possible stage. As the clinical course evolves, and the surgeon develops a relationship with the family and the patient, it becomes progressively more difficult to remove herself from the treatment team.

Palliative Care/Hospice

General principles

Focusing on making the last months, not minutes, of life meaningful is especially appropriate where death has a significant predictability. Chronic progressive diseases such as cancer, congestive heart failure, and chronic obstructive pulmonary disease account for 50 to 70% of deaths, compared with the sudden death attributed to stroke, heart attack, trauma, and suicide. In the United States patient's perceptions of human finitude lead them to deny death and to rely on medical achievements that they think will let them live forever. Physicians grapple with their technological power, the imperative to tell the truth about fatal conditions, and despair at denying hope and the promise of cure for their trusting patients. It is probably this mutual self-deception that becomes the central issue in rendering appropriate end-of-life care. It is the management of these intense psychological and spiritual challenges facing terminally ill patients that has come to form the basis of what is called *palliative care*.³¹

A brief definition of *palliative care* would be: the act of *total* care of patients whose disease is not responsive to *curative* treatment. Although *palliative care* has been a major focus in Europe for the past 20 years, interest in the United

States only became significant in the late 1990s with an Institute of Medicine report that evaluated end-of-life care. It revealed significant deficiencies in how we manage end-of-life care. These deficiencies include the management of pain and other symptoms, including nausea and vomiting, dyspnea, depression, and anxiety. Geoffrey Dunn explains that: "palliative care is not a concept defined in terms of the amount of time remaining in a patient's life or the terminal nature of his disease. It is defined in terms of the type of need that is being met by the care."³⁵

The concept of *palliative surgery* refers to surgery for which the major intent is alleviation of symptoms and improving quality-of-life, *not necessarily cure*. As the age of our surgical patients increases, we will be progressively involved in performing operations whose desired outcomes are not met. Managing these patients through the entire course of their disease, including death, is an important part of being a good physician and a good surgeon. Surgical emergencies are often the first encounter with older patients, and they often have multiple comorbidities. An example is the 80-year-old person who presents with an acute abdomen. The risk of surgery will be high, the prognosis may be poor, and cure may be impossible. Perhaps, offering surgical treatment would even be inappropriate. Thus we, as surgeons, are immediately thrust into contemplating *palliative care* for the surgical patient; and it becomes clear that surgeons need to be aware of the concepts involved in delivering such care.³⁵

Pain relief and the Doctrine of "Double Effect"

Confusing Principles

When it comes to adequacy of pain control, especially for patients near the end-of-life, physicians and surgeons have been caught in a complicated dilemma. On the one hand most of us entered medicine to relieve suffering. On the other hand we know that administration of excessive doses of pain medication can suppress respiration and run the risk of contributing to the death of patients already near the end-of-life. At the same time that we are criticized for not giving enough pain medication to our suffering patients, we are also challenged by the law for prescribing medication with the *double effect* of potentially *hastening death*. This doctrine of *double effect* is intended by the courts to recognize the difference between provision of adequate pain treatment that unintentionally causes death and the ordering of medication that intentionally causes a patient's death. This concept of *intent* is confusing not only for the courts but also for the physician who is ordering the pain medication.

Double Effect

The application of the principal of *double effect* is controversial because it places significant weight on physician *intent*, which is impossible to prove; and no weight on a patient's right to self-determination. This seems to contradict a paramount principal of American bioethics: *patient autonomy*. Why, when death is on the line, should concern over the physician's *intention* take precedent over the *patient's informed consent*? The physician's fear over misinterpretation of his or her actions often leads to inadequate use of pain medication, leaving patients unjustifiably suffering. It is clearly recognized that opioids should be considered early in the care of the dying patients and in dosages that often exceed the standard range. These analgesics are not only effective in reducing painful sensation, but also have an effect in adjusting the sense of well being, thereby improving the patient's ability to cope with pain. Adjustment of dosage can be aided by using one of the known *pain scales* or by observation of patients' objective signs of distress, especially useful in the non-communicative patient. Despite its significant effect on several components of respiration, respiratory arrest from opioids, in the absence of other central nervous system depressants, is rare. In caring for dying patients, surgeons must acknowledge that they are one part of the often-fragmented medical team. They must accept the goal of providing care where they can, comfort always, consult when necessary, and coordination of the remaining end-of-life issues.³¹

Hastening Death: The "Code"

Since the overwhelming admonition to the physician is "above all do no harm", society has implored the surgeon, in life-threatening situations, to waive informed consent requirements and to act presumptively to save life or limb in situations where the usual consent is impossible to obtain. This leads to our current default in dealing with the critically ill or moribund unknown patient: resuscitating with "a full code" and asking questions later. This practice is probably acceptable as long as the surgeon realizes that *withdrawing life-support* is just as acceptable as *withholding life-support* initially. The initial full resuscitation may make it possible to assess the patient's end-of-life desires more fully and carefully. If the initial intervention is unsuccessful or is inconsistent with the patient's preference, it can and should be withdrawn, consistent with the patients identified goals.

What are ethically frowned upon are such deceitful practices as the "slow code", a charade consisting of a halfhearted resuscitation that seems to allow the surgeon to take the moral middle ground by giving the family a false impression of respecting patient autonomy, while knowing full well that the act will not be effective. Experience suggests that this hedge is used fairly commonly. Although

no ill is usually intended, the slow code is usually an indication that the surgeon has not realistically communicated with the patient and family to express the medical opinion that resuscitation, in the face of cardiac or respiratory arrest, would be inappropriate.³¹

The concept of "no code" should be clear, and is usually instituted at the request of the patient, his advance directive, or an appropriate surrogate. It is ethically inappropriate for the physician to disrespect the patient's autonomous decision even when faced with despairing surrogates requesting interventions over a clear directive to the contrary. The patient with decision-making capacity is, of course, free to change any prior stipulation, even those written in an advance directive. In the absence of any directive, including a decisional patient, the physician must employ *best interest standard*, which requires implementing what a *reasonable patient* would want done in a similar situation.

In order to understand these previously discussed concepts, the surgeon must realize the implications of the three means of accelerating death for patients in the United States: *double effect*, *voluntary euthanasia*, and *physician-assisted suicide*. The *rule of double effect*, as previously described, involves the dichotomy of treatment versus side effects, where death is the *unintended* side effect of adequate symptom control. *Voluntary euthanasia*, that which is requested by the patient, can be either active or passive. *Passive euthanasia* is the result of withdrawing or withholding life-support in situations judged to be medically futile. In United States this is both ethically and legally acceptable. On the other hand, *active euthanasia* occurs when the physician *intentionally* administers an agent to cause a patient's death. This act is considered *unethical* and *illegal* everywhere in the world except in the Netherlands where it is practiced openly. *Physician-assisted suicide* occurs when a physician supplies a death-causing agent to a patient with the knowledge that the patient intends to use this agent to commit suicide. In United States, this practice is legal only in the State of Oregon.³¹

Of great concern to all physicians in United States, is a recent action by the Attorney General of the United States with regard to the Oregon Death with Dignity Act, a law that authorized doctors to help their terminally ill patients commit suicide. The doctors were allowed to prescribe, but not to administer, such drugs. Attorney General Ashcroft, in 2001, directed that doctors who help their patients commit suicide could be prosecuted under the federal Controlled Substances Act. This was the first example, in United States, of the *federal government* interceding in the practice of medicine, historically entrusted to *state lawmakers*. In May of 2004, the United States Court of Appeals for the Ninth Circuit, in San Francisco, rebuked the Attorney General and upheld the Oregon law.^{36,37}

Know Your Intent

For all physicians, the concept of avoiding killing seems obvious. However, what is a doctor to do when confronted with a situation whereby the administration of sufficient medication to alleviate the pain of a patient might have the secondary effect of diminishing respiration, and actually hastening the death of the patient? This is, of course, the crux of the major debate over physician-assisted suicide and euthanasia. There are other situations, such as abortion, where a physician must take avoiding killing into account. Confronting such issues challenges a surgeon not only with the duty to respect the autonomy of the patient but also to be aware of situations which might put the individual doctor in the uncomfortable situation of confronting conflict with his or her own personal beliefs.

In multiple decisions, the courts have emphasized the importance of distinction between "letting a patient die and making that patient die".¹⁸ This, in our opinion, is the most distressing conflict for the physician who must make such decisions. We know full well that when we give high dose opioids or withdraw ventilatory support, we may be hastening the patient's death. The callous ones among us see this as euthanasia and strongly criticize those who claim otherwise. When confronted with this challenge, in a personal communication, Dr. Edmund Pellegrino, one of our most respected medical ethicists, immediately responded with his comforting interpretation of such a situation. In his mind, and in his conscience, he recognizes and acts upon the difference between actively and intentionally hastening a patient's death as opposed to relieving pain and suffering or withdrawing artificial life-support, thus "letting nature take its course".

DETERMINATION OF DEATH

The attending physician has the discretion and the responsibility to determine death. Statutes in different states use different criteria for death. In some cases they have not caught up with the science available. Some states use the "irreversible cessation of cardiopulmonary function" criteria, as do some religions. The complete cessation of respiration and circulation constitute "death" under this definition. The concept of *intensive care* has advanced dramatically since these statutes were enacted and have superseded this now antiquated definition. In most states where this is the statutory definition, the courts have now ruled that "brain death" suffices.

Most states use the brain death criteria. There is debate currently about whether the "whole brain" definition of death is no longer valid; and that the appropriate ethical standard for definition of death is cessation of "higher brain"

function. Higher brain function includes the cognitive functions or the capacity for consciousness. Once there is irreversible cessation of that capability, a judgment usually made in consultation with a neurologist, then death can be declared. Most neurologists are trained to determine whether death has occurred or whether the patient is in a "permanent vegetative state".

It should be noted that in some states the definition of death includes either the *cessation of cardiopulmonary function* or *irreversible cessation of all brain function*, including the brain stem.

The healthcare team, however, should realize that no matter which criterion is being used, it may be appropriate to continue cardiovascular support for the purpose of maintaining perfusion during the eminent birth of a fetus, or to sustain viability of transplantable organs.

ORGAN DONATION

Criteria for organ donation are not always clearly understood. Many patients and families are mistakenly concerned about having death declared prematurely just to facilitate the harvesting of organs for transplantation. Here the surgeon's bioethical responsibilities are clear. The medical ethical principle of *patient autonomy* dictates that the desires of the patient and the family be respected.

Federal law requires most hospitals to make an inquiry of all patients, during their admission, for any procedure, whether emergency or elective, about their wishes to be a potential *organ donor*. While this can be somewhat of a shock to patients who are coming in for elective surgery, especially a minor procedure, it obviates the need for physicians to make the painful inquiry when a patient is actually facing eminent death. If the admitting personnel ask for this information on a routine basis, the patient is more likely to render a competent decision; and the potential problems of dealing with surrogates, sometimes under difficult circumstances, is alleviated.

However it is obtained, *informed consent* of the donor is required. Most states provide organ donor options on driver's licenses, and many people possess other documents such as donor cards, which indicate their desire to become organ donors. In some cases donors request limits on the organs they wish to donate. For example, some donors have indicated that they do not wish to donate their eyes or some other specific organ. Even though patient autonomy should guide the physician, there are circumstances where the family emphatically wishes to override the clearly stated intention of the donor. These situations are difficult, and while the surgeon's clear ethical duty is to respect the wishes of the donor, the body of the donor, after death, belongs to the family. The treating physician would be well advised to leave the resolution of this situation up to the transplant

coordinator. In fact, it is usually inappropriate for anyone on the treating team to initiate the discussion of organ donation. Most hospitals have in place a procedure whereby the discussion of potential organ donation is initiated by a person specifically trained for this purpose. It is often the transplant coordinator, a social worker, or a hospital chaplain.

Insisting on compliance with the donor's clearly stated wishes, in the face of strong family opposition, does not effect the legal position of the surgeon; but it can result in unfortunate lawsuits because of the animosity created with the family. In cases where there are no previously expressed wishes by the potential donor, the family, as custodians of the body, may agree to organ donation. The duty of the physician in this case is to obtain the consent of the family before doing anything to preserve the functioning of the organs for potential transplantation.

In cases where there is no surrogate or family, nor any evidence of previously stated intention to donate, the ethical position of the doctor is less clear; but absent permission to do something to the body in a situation which is no longer an emergency, assuming that the organs should be harvested for transplantation would seriously violate the concept of informed consent. While it can be argued the dead person cannot give informed consent, the family whose property the body is, would have to give their consent to have any procedure done at all to the newly dead person. In cases with no directives at all, the best course of action, unfortunately, is to do nothing postmortem.

ETHICS/LEGAL CONSULTATION

Most surgeons work within an institution. Most of these institutions provide a mechanism for obtaining help in sorting out challenging ethical dilemmas. This help usually comes in the form of consultation from the hospital *Ethics Committee* or from in-house *legal consultation*. It is critical to realize that utilization of such a resources does not commit to the surgeon to accepting an arbitrary decision of what is right and what is wrong in a complicated ethical situation. Consultation is meant to provide a process for most expeditiously sorting out the issues, which have arisen and for providing rapid access to the potential mechanisms for solving the problem. Hospital ethics committees are specifically charged to advise physicians, patients, and families who face ethical dilemmas. These situations usually arise when there is *disagreement* between these groups and the health care team. Consultation from the ethics committee is usually rapidly facilitated through such agencies as the hospital nursing service. Consultation should be available, instantly, 24 hours a day. Frequently it is the hospital chaplain who facilitates the consultation. By bringing in appropriate resources and facilitating meeting with the

health care team, patients, and families, consultation with the ethics committee should help resolve even the most complicated medical ethical challenges. The hospital ethics committee should be charged with what is the right thing to do for the patient. It should have no vested interest in protecting the institution at the risk of embarking on an action, which is ethically unsettled for the good of the patient.

A word of caution, however, is necessary for surgeons working within a given institution. Once *legal counsel* or *risk management* is brought in to deal with a complicated situation, it must be remembered that *they work for the institution*. Their job is to protect the institution, and the advice that they give will be aimed toward that end. This commitment to the institution is important for the physician to realize if there is potential for placing oneself in personal jeopardy. It is also important to realize that legal standards are not always reliable guides to determining what are the best ethical and medical decisions.

GOOD SAMARITAN

A Case

The most skilled colon and rectal surgeon in town is out to dinner. At the next table he sees the local crime boss choking to death over a piece of prime beef. What are the ethical and legal considerations he must consider before performing an emergency tracheotomy? What is he ethically obligated to do? Is the old medical oath binding? Can anyone give consent? Must he identify himself? If he performs the procedure, and there is a bad outcome, is it malpractice? What if he is a medical student instead of a famous surgeon? Is a bad outcome here considered battery? What should the surgeon do when the EMT arrives and wants to take the dying crime boss to a known inferior local hospital? What are the obligations and risks for the surgeon?

General Concepts

Good Samaritan acts or deeds are defined as those in which aid is rendered to a person in need, where no fiduciary or legal obligation exists to provide such aid, and neither reward nor remuneration for the aid is anticipated. The aid provided can include a survey of the situation, protection of the victim, notification of other care providers, or personal provision of immediate treatment. The Good Samaritan Ethic is one that is generally endorsed by our culture, which strongly supports assisting an individual who is in danger or in need of help. Surgeons may be regarded as having a greater responsibility to provide Good Samaritan aid than a lay person by reason of the special training and knowledge and commitment to duty for the benefit of individuals and society which generally drive us to become

physicians and surgeons. Clearly, in a situation of sudden medical need, a surgeon will be better able to assess the medical condition of the victim and to render immediate treatment if indicated and feasible. Many feel that the mere status of being a physician entails the duty to use one's skills and knowledge in cases of sudden or emergency need; for some this duty is an inherent feature of the role and even of the definition of a physician.³⁸

Briefly stated, in almost every state, an off-duty surgeon who comes across a person with an emergency medical condition has no *legal duty* to come to the aid of that person. However, a physician's *ethical obligation* inspires him to help in such an emergency. All states in the United States have enacted so-called "Good Samaritan" statutes, which protect the physician from liability incurred for good-faith efforts to help at the scene of an accident or emergency. The ethical duty should far exceed the legal excuse for inaction.²

Generally, Good Samaritan acts include the following principles: 1. There is no legal obligation of doctors to answer or treat emergencies. 2. If the doctor chooses to intervene, the expected standard of care is modified by circumstances of the situation. 3. If aid is given, it need be stabilization only and not definitive treatment. 4. Implied consent exists to treat the victim if he or she lacks the capacity to consent. 5. These criteria apply whether or not the physician is paid for his or her services rendered. Despite the establishment of these principles, the extensive coverage in the media of spectacular medical malpractice suits causes many surgeons to develop a strong aversion to the performance of Good Samaritan acts. In order to alleviate this apprehension, Good Samaritan Laws were enacted, the first in California in 1959. Since then every state has enacted such Law. The laws all share the following provisions: there is no legal obligation to provide aid, there is immunity from malpractice suit if aid is provided, there is exception from immunity for gross negligence or lack of "good-faith", acts are restricted to application outside of hospitals, and there is withdrawal of legal immunity in the doctor accepted payment for aid rendered.³⁸

PROFESSIONALISM AND INTERPERSONAL RELATIONS: WORKING AS A TEAM

General Considerations

There is an ever-increasing challenge to deliver the very best surgical care in the current medical environment which thrives on its speed and frequently impersonal delivery of generic medical care, often at multiple institutions, and without one consistent team of support. Often it becomes difficult to fulfill the responsibility requiring communication, collaboration, respect, and confidentiality as we interact with the components of our health care team which frequently

includes nurses, enterostomal therapists, primary care physicians, consulting physicians, surgical and medical trainees, and the vast array of ancillary services required within our institutions.

Teaching Residents and Fellows

Learning and teaching are critical components in our career choice of medicine, and especially, surgery. At some point in our training, a more senior person turns over to each of us the responsibility to perform the major part of an operative procedure. And then, the converse occurs: each of us, in turn, relinquishes the major part of an operation to one of our trainees. We know how the process works and the importance of a surgical team with "graded" responsibility. The ethical challenge arises when, often the night before surgery, the patient asks: "who is going to do my surgery?"³⁹ The honest answer becomes blurred, especially for those colon and rectal surgeons working in a program with trainees who are senior residents or fellows. We usually fall back on the explanation that we, the attending surgeon will be present and responsible, even when we know that the trainee will be doing the critical part of the procedure. What is the truth? The fellow claims on the training record that he or she did the case; and we charge the payer as if we did the procedure. What is true *informed consent* in such situations?

Previous Suboptimal Care

General Concepts

As colon and rectal surgeons, we are specialists, frequently seeing patients as requested consultation by and referral from other physicians and even other surgeons. It makes the nature of our care, often, "the end of the road". We have no place else to send the patients and frequently find ourselves in the position of correcting or undoing the poor results of the action of another surgeon. This becomes an ethical and personal challenge especially when the patient or the family asks: "Why wasn't that done by the other surgeon, or what did she do wrong?" We can easily become caught up in the dilemma between taking credit for heroic restoration of health and condemnation of the other surgeon, or, covering up for incompetent care in an attempt to avoid litigation against another doctor and/or preserving a lucrative source of referrals.

Generally our surgical and specialty training does not prepare us for the ethical differentiation between "bailing out" and "condemning", responding to patients' pointed questions, communicating with the doctor responsible for the suboptimal care, and certain not "blowing the whistle" on another surgeon and going

to court, when requested, as an "expert witness". Albert Wu suggests that a surgeon who discovers a major error made by another physician has several options, which include: waiting for the other doctor to disclose the mistake, advising the other physician to disclose the error, arranging a joint meeting to discuss the mistake, or telling the patient directly. He and his coauthors believe that, based on the requirements of the doctor-patient relationship, surgeons have an obligation to facilitate disclosure. Many surgeons are reluctant to say anything because they aren't 100% sure of what actually happened, they fear hurting the feelings of colleagues, they wish not to strain professional relationships, or because of the terrifying thought that "there but for the grace of God go I". Wu further suggests that we fulfill our obligation to our patient by advising the doctor who erred to inform the patient; but he goes on to say that if that fails, it is our duty to tell the patient what happened.⁴⁰ Each of us must then rely on compassion and tact to tell our patients the truth without unduly condemning the other physicians. We surgeons need to realize that what we take for granted in our weekly *morbidity and mortality* conferences, especially in a teaching hospital, is not the norm for other branches of medicine. We know, and perhaps are obligated to pass on to others, that admitting a mistake may help us to accept responsibility for it and may help to make changes in our practice. Physicians should be able to learn vicariously from mistakes made by others, and thus avoid making the same mistake themselves.⁴⁰

"Blowing the whistle" and Going to Court

The next echelon of concern and potential activity, of course, involves serving as an "expert witness" in medical malpractice litigation. Again, this is an arena of involvement in the medical-care system for which we surgeons are generally ill prepared. Just recently, the American College of Surgeons and the American Society of Colon and Rectal Surgeons has issued some guidelines in an attempt to insure that surgical specialists not abuse the system by offering false testimony or by presenting as "experts" in areas beyond their expertise. Many of our true experts refuse to serve in this capacity when it involves saying something against another surgeon; yet, when any of us are involved as the accused, we want only the finest experts available and are repulsed when "hired guns" with little knowledge boldly testify against us. The problem seems to be that many of us don't differentiate *malpractice* with severe damage to a patient from the poor results from proper treatment which we surgeons all experience in dealing with the complex biological system of the human body. Again, the principle of not stepping up to the plate for fear of the dictum, "There but for the grace of God go I". We should understand that credibility in the medical-legal system should be based on

true expertise and on telling the truth, be it for the plaintiff or for the defense of our colleagues, and, in fact, we can be of much greater help to inappropriately accused physicians by establishing such a record of credibility.

Managed Care

Patient Advocacy

All of us, in the current system, participate in some form of managed care, where someone other than the treating physician becomes involved in the mechanism of delivering care to our patients, usually without sharing in the responsibility of rendering the care and the untoward outcome that may be engendered by that care. This presents a true dichotomy for doctors, most of whom have taken an oath or by law, are committed to being *advocates* for our patients. It seems an impossible, and perhaps unethical, task to make a decision, which favors the economic advantage of a managed care organization over what we know, medically, is required by an individual patient in need.

Rationing Care/Cutting Corners

Surgeons have a special obligation to deal with these systems because of the loneliness of making the decision and ultimately doing a surgical procedure on another human being. It is a desperate feeling to realize, in the middle of an operation, that our quest for perfection has been compromised by some inadequacy in preoperative management foisted on us by another remote physician hired by a managed care organization to protect the financial interests of a group. We know, as well as others, that medicine, as a system, is in trouble; but the problem is rarely to be solved by rationing or withholding what we know is surgically best for our individual patients. Perhaps it is our job to invoke our "surgical personalities" to become the strongest of all patient advocates and to fully participate in achieving needed improvements in the overall system. We must communicate to others the special understanding and compassion few outside of the field of surgery understand.

PERSONAL CHALLENGES: COMPETITION OF INTERESTS

Professionalism

McKneally describes the profession of medicine and surgery as a vocation that requires extensive knowledge and skill. It also requires a high level of discretion and trustworthiness, even in individual practice. The social contract between the profession and the public holds professionals to very high standards of competence and moral responsibility. He goes on to explain that a profession is

literally a declaration of a way of life "in which expert knowledge is used not primarily for personal gain, but for the benefit of those who need that knowledge."¹⁹ In our current society, bombarded by endless advertising and hype, many groups call themselves "professionals" sometimes to the point of humor; but for those of us in medicine, and especially surgery, the definition means that when confronted with a choice of what is good for us or what is good for our patient, we choose the later. This occurs and is expected sometimes to the detriment of our own good and that of our families. Tom Krizek even goes so far as to question if surgery is an "impairing profession".⁴¹ Perhaps it really is an *ethical* concern, which is encouraging us to modify the working hours and conditions for our trainees to offer more of an incentive to enter the surgical specialties. Now that we have appropriately tended to the training programs, it behooves us to explore the same life-style improvements for ourselves. It is neither an ethical breach nor a sign of weakness to allocate high priority to our families and to our own well-being.

Family

As financial and professional pressures become more intense, the challenge increases to appropriately prioritize and balance the demands of patient care, family, education, teaching, and research. Mary McGrath presents an all too frequent dilemma for the surgeon: choosing between attending a child's graduation or operating on an old patient who requests you instead of your extremely well-trained associate who is currently seeing the patient. How many times have we not chosen wisely! Someone else can competently care for your patient, but only you can be a parent to your child.¹⁹ Time literally flies, and we must often remind ourselves that our lives are not just a "dress rehearsal"!

Among the many considerations of *family* is the issue of caring for, and perhaps even operating on our own family members. What is not only ethical, but what is appropriate for the practice of medicine and surgery with regard to this issue is not as clear as you might, at first, believe. For example, if your spouse cuts her leg while skiing, and the only available physician is a psychiatrist who is covering the ER, should you, a training surgeon, suture her laceration? On the other hand, if you feel that you are the most experienced colon and rectal surgeon in the community, what should you do when your own mother is found to have a complicated cancer of the low rectum? After all, if you are the "best" why would you deny the best care to your own mother? Many hospitals have dealt with this issue and have a stated policy. The AMA has issued a statement on "Self-Treatment or Treatment of Immediate Family Members". In essence it speaks against treating family except in emergent situations and for short periods of time. It is, of course, based on the risk of compromise of professional objectivity

and influence on medical judgment because of the influence of personal feelings, thus interfering with the care that needs to be delivered.⁴²

Competence/Impairment/Insight

Surgical certifying organizations are currently struggling with the definition and determination of *surgical competence*. McKneally stresses that a patient's trust is based on the surgeon's diligent pursuit of competence in both judgment and technical skill. Surgical training programs have diligently attempted to guarantee the competency of individuals completing the process. The board certification process attempts to ensure that the interests of society are represented in these professional processes. Thus, competency is an integral part of the *entry-level*. The problem arises in maintaining a level of competence and assuring that established surgeons who take on new procedures both acquire and maintain competence in these new skills.¹⁵ Perhaps the most obvious recent example for us colon and rectal surgeons has been the advent of laparoscopic, minimally invasive surgical procedures. Now that they are part of all Fellowship training programs, it is less of a problem. But the issue will arise again with the next new wave of technology: how to teach old surgeons new skills.

Related to competence is the issue of *impairment*. Jones emphasizes that drug and alcohol abuse, with the associated functional impairments, are the leading cause of sanction against physicians by professional oversight bodies in the United States. More than one in every seven physicians is affected by substance abuse at some time in their careers. He goes on to explain that the surgical patient is potentially at greatest risk in the care of a cognitively or physiologically impaired physician because the surgeon's competence requires simultaneous application of fine neuromuscular, cognitive, and intellectual skills. This is coupled with the emotional composure and critical judgment required to make urgent decisions and the physical endurance of standing for long hours at the operating table. He cites Percival's admonition that the medical profession is a "public trust" that should be relinquished when a physician or surgeon no longer possesses the skills that are essential to clinical care. Unfortunately, most surgeons don't possess or exercise the insight required to know when we are impaired or when it is time to retire.

Jones goes on to quote Verghese's observation on the impaired physician: "the doctors had one common feature - namely, exquisite denial - that allowed them to believe they could still care for patients perfectly well".⁴³ These observations place great responsibility on those of us who observe *impairment* or *incompetence* in our colleagues who at times may also be or close friends. We should never hesitate to request intervention because correction of substance

abuse in physicians is highly successful. If we stand by and allow patients to be mismanaged by inadequate physicians, we will not only see the patients suffer but will allow our colleagues and friends to be destroyed professionally and perhaps devastated emotionally by malpractice suits, condemnation by institutions and colleagues, loss of licensure, and eventually the ravages of substance abuse or personal humiliation.⁴³ Most state boards of healing arts function best when it comes to providing support for physicians in trouble.

VII. A FINAL THOUGHT

Perhaps Richard Hayward, who compares a surgeon to the young sea captain in Joseph Conrad's novel, "The Shadow-Line", best describes a successful career in surgery. Hayward explains that there are so many variables in the interaction between patient, surgeon, and disease that it is not surprising that the prediction of results becomes uncertain. Even routine procedures can produce complications and can become much more difficult than had been anticipated. As the surgeon crosses Conrad's Shadow-Line, energy, enthusiasm, ability to make firm decisions and then act upon them, optimism, self-confidence, and resilience in the face of adversity become necessities without which an individual will have difficulty coping with the pressures of a surgical practice, especially one involving the care of critically ill emergency patients. There becomes a time when a surgeon must learn to come to terms with the inadequacies and, sometimes, downright failures of his or her actions that will be the inevitable companions during a surgical life.⁴⁴

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LEGENDS

Figure 46-1. The four topics: case analysis in clinical ethics. (Reprinted by permission: Jonsen AR, Siegler M, Winslade WJ. *Clinical ethics: a practical approach to ethical decisions in clinical medicine*, fifth edition. New York: McGraw-Hill; 2002.¹³)