

CHAPTER 38

Ethics and Laparoscopy—Concert or Contest



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We all learn about ethics throughout our lives and ethics are the backbone of patient management.

It is difficult not to be pretentious while discussing ethics and I welcome any criticism as a test of my own opinions and convictions. I am writing this paper as a practicing surgeon who served in the Army from 1972 to 1974 and then as a private practitioner until 2000, when I became a full-time department of surgery chairman and program director. I have been *there* in clinical practice, and I am still there, at our University-affiliated community hospital.

Physicians, medical students, and nurses have forced me to re-examine many ethical dilemmas and pathways of patient management. Memories of past poor leadership have stimulated thinking about alternative solutions that would have been better. These positive and negative pressures have shaped many surgeons' ethics. A surgeon is an amalgam of good and bad experiences, and we try to accentuate the positive, and build on strengths. Certain ethical issues are addressed with a series of questions, and often there are no absolute answers. Interactions between members of the healthcare team, as well the hospital or the payors, or the politicians or the lawyers, are unavoidably interwoven. I have purposely written this chapter without reading the most updated ethics guidelines in the (1) *American College of Surgeons Statement of Principles*.

The dynamic of ethics is best served when the healthcare team makes the process a concert and not a contest. Many ethical decisions can be made on a personal basis and not by a large committee. If a meeting is called, someone should be present who can actually create or enforce a change or guideline. Most decisions can be made with input from the involved parties, layered with input from other individuals who might be affected by the outcome of a decision. All parties should be heard and no decision should be made after hearing only one side.

On occasion, we surgeons have been accused of being "sometimes wrong but never in doubt." Frequently, preoperative decisions are modified during the conduct of an operation. Sometimes an operation can be quite difficult but because of careful team decision making, the surgery can be optimized. If a contest is created by any member of the team, the outcome can still be good, but the operation perhaps did not take the same elegant pathway. So at the operating table, patient safety must be the overriding ethical consideration. It is

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everyone's responsibility to create an atmosphere where the patient must come first, and everything possible must be done to maximize that effort. The team is both audience and participant in the concert.

If the overlying theme of surgery is patient safety, how can we instill comfort and confidence in the patient? We should pretend that we are the patient and ensure that the planned operation or steps during the operation would be the same ones we would want performed on our loved ones. That particular overture usually reassures patients and is one of the moments that they will recount at subsequent office visits. The *golden rule* has been one of the most consistent check points in my practice.

One way we are led to truth is by following level I evidence. The postoperative drain in the gallbladder bed was a *truth* for many years. Eventually, level I evidence and surgical expediency led surgeons to abandon that drain for most cholecystectomies and many other types of surgery. Ethics should not be used to pronounce these kinds of surgical maneuvers good or bad. We will not debate whether only level I or II evidence must be cited to bless one management pathway over another. Ironically and maybe ethically speaking, even if many surgeons are aware of level I evidence, there is no guarantee that management of a particular situation will change. For example, the *New England Journal of Medicine* published an article, "Arthroscopy for Osteoarthritis of the Knee?"⁽²⁾ Even though this article appeared on July 11, 2002, there has been no change in the number of patients who have undergone knee arthroscopy for osteoarthritis. We cannot argue the subtleties of knee arthroscopy for osteoarthritis, but it is an interesting ethical issue. General surgeons, however, must also recognize that it took 2 decades to abandon jejunoileal bypass for obesity because of an *unacceptable* complication rate. That prolonged abandonment was a system process failure. Was there a long enough evaluation process before jejunoileal bypass was popularized? Apparently, there was not. Presently, **the payors are the impresarios**, and they either cover certain procedures or drop them as approved for reimbursement. The payors are in effect a fork in the decision tree for legitimizing and popularizing a new procedure. The decision to perform a given operation or use a particular device hinges on the probability of reimbursement, even before we have to deal with any ethical issue. The other side of the equation is that the long time it takes to abandon a procedure proven to be dangerous can be much longer than the time it takes to approve the procedure.

One of the most controversial areas in surgery is the efficacy and adoption of **laparoscopic versus open laparotomy** with regard to certain organs. Whether a surgeon learns a laparoscopic approach instead of a traditional open approach has implications that affect surgeons' incomes. The choice for many is simple. Some may decide change is necessary in order to practice in their locality. Some may say that since no one is performing laparoscopy, they do not have to learn those skills. We must enable change by providing more and better coaching. Each surgeon must examine motivations, and success will be expedited by self-critical ethical approaches. The learning curve for many procedures varies from two

to at least 20 cases and probably more. The learning curve is more prolonged with gastric bypass and sometimes never ending. The degree of difficulty of a typical laparoscopic cholecystectomy has been quantified by Dr. Schauer.⁽³⁾ On that scale, laparoscopic gastric bypass is a 9.5 and laparoscopic cholecystectomy is a 3.0. Difficult decisions in laparoscopic surgery relate to two ethical questions. First, how much proctoring is necessary for a given procedure? The second question is, if a surgeon is only capable of performing a procedure with a laparotomy incision, should that surgeon refer the patient to another accomplished, respected, laparoscopic surgeon within the same locality?

The decision to attempt a laparoscopic procedure such as hiatal hernia repair, adrenalectomy, or colon resection should be made by a surgeon who can say that he or she would be comfortable with someone like him or her operating on him- or herself. We would not be comfortable with an inexperienced surgeon taking a chance with our own surgery. The golden rule works for everyone.

It should be possible to get experienced help from an associate or a proctor paid by a hospital and or surgeon. Many of us have operated in concert with residents or other surgeons, and the process of operating safely and yielding to the surgeon who at times must take over, is a well-respected feature that we have endured, as well as performed. That is part of the concert. I am not suggesting that laparoscopic surgery should always be performed. There are many localities where laparoscopic expertise does not exist and there is no choice but an open approach. Also, a hostile surgical abdomen may eliminate the patient as a candidate for a laparoscopic approach. On the other hand, is it reasonable for a patient to have an open procedure such as cholecystectomy when many surgeons can prove by their numbers that they could do a *lap chole* safely? Can we substitute the word *ethical* for *reasonable*? We may. In the eyes of patients and medical referrers, the smaller incisions and same-day discharge for lap chole has minimized the invasiveness of the procedure. Indeed, many patients will comment that taking their gallbladder was not really *like an operation*. Our own high expectations and the laparoscopic industry continue to propel patients and surgeons toward minimally invasive surgery. Our training methods must be improved in order to create a properly confident surgeon, who could comfortably follow the golden rule. Some laparoscopic procedures have not become very popular, such as inguinal hernia repair. An article in the *New England Journal of Medicine* indicated that unless a surgeon performed 250 laparoscopic inguinal hernia cases, at least a 10% recurrence rate could be expected.⁽⁴⁾ But there are many procedures such as hysterectomy and oophorectomy that perhaps should have wider laparoscopic popularity than exists. Are gynecologists simply less willing to change from an open to a laparoscopic approach? Are they unethical if they do not either attempt to learn the laparoscopic approach or send the cases to a laparoscopic surgeon? Is it nicer to say they may just be a little unreasonable? What would you do if it were a female relative who needed the procedure and the safe laparoscopic alternative was next door? Much of this issue will be settled as more and more surgeons are trained in laparoscopy. The

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majority of abdominal procedures today can be evaluated as to laparotomy versus laparoscopy approaches.

As a chairman of a department of surgery, issues of privileging and credentialing are part of the job. The task is less difficult when a new surgeon arrives who has completed a fellowship. Conversations with his or her mentors and supporting letters and case documentation should support that surgeon. Intraoperative proctoring hopefully further supports that surgeon. The rules and regulations regarding proctoring are, at most, guidelines for most hospitals and the actual observation times of new surgeons can vary. In some cases, older partners or other full-time surgeons can readily proctor a new surgeon. In many cases, however, surgeons in solo practice have difficulty finding any *convenient* time for any proctor to help. Also, proctoring may include observation of the operation only, observation and commentary during the operation or, observation, commentary, and direct assistance during surgery. At times, it may be necessary for the proctor to take over the surgery if, in the judgment of the senior surgeon, the operation is not *going well*. We have no national standard for proctoring and we should. We are aware that in certain hospitals, surgeons have been given full privileges and have never been proctored. Only in the case of recurrent problems do hospitals take steps to curtail privileges. Responsible procedure proctoring is a system issue that has many ethical nuances, and we should address the issue of proctoring on a national level. How can one not expect complications if one is early in the learning curve? What help should one expect at surgery? Why do we not have a system where there is reimbursement for routine proctoring within a hospital? Does any conductor or first violinist donate his or her services or lessons to any orchestra on a weekly basis? We have no doubt that the availability and intensity of proctors would be substantially improved with a reimbursement schedule for proctoring services.

On the one hand, the patients' enthusiasm for minimally invasive surgery (MIS) because of less pain, smaller scars, and faster discharge has been augmented by the medical industry fostering the techniques. On the other hand, the MIS misadventures have also led to many malpractice allegations. **The learning curve for many operations is simply not tolerated by our current legal climate.** Surgeons have been forced to abandon certain operations and even leave surgical practice because of high malpractice insurance rates, subsequent to a jury or settlement award. **Root cause analysis** of any complication can be implemented to try to prevent reoccurrence, and a malpractice review should not be the primary stimulus. How often is root cause analysis used in surgical departments? How often are complications filtered out of any form of review, and openly discussed, without any possible backlash? That analysis activates the transparency ethic. Unless we monitor, admit, and correct our errors, many aspects of surgical ethics will not be addressed.⁽⁵⁾ Our own departmental and self-analysis of errors represent part of the rehearsal for the next concert. In our outcome studies, we have presented instances where the surgeon has recognized that a less aggressive surgical approach should have been taken. On the other hand, our quiet,

private, victories for avoiding surgery where *less is more* are part of our daily practice and are never properly valued by the payors. Surgical judgment becomes integrated with our technical maneuvers and occasionally all of us need the judgment *metronome* regulated faster or slower. We must be open to criticism of any management pathway, and any part of the team must be empowered to question the care of a patient.

The entire issue of assessing one's own results has not been addressed by many surgeons. We are not forced to keep track of the number of any operations we perform, nor any complication list. We may do an occasional debriefing postoperatively, but it is not a universally adopted notion. Interestingly, in our early schooling, we formatted experiments using the scientific method consisting of hypothesis, materials, method, results, discussion, and conclusion. Most surgeons do not keep personal complication logs, or scientifically review results and change approaches. Many surgeons are anecdotal doctors who are quick to quote personal, inaccessible, unverified data. We all should have a simple, rapid way to transcribe our data and review it personally and regularly. Hospitals may have records of wound infections, readmissions, reoperations, and sentinel events, but those complications underestimate the total complication rate. In addition, it is rare to find any hospital that tallies individual surgeon complications. One exception is heart surgery, where many cardiac surgeons fill out the *The Society of Thoracic Surgeons Adult Cardiac Surgery Database Annotated Data Collection Form*.⁽⁶⁾ The results of the self-examination of cardiac surgeons has led to a remarkable decrease in complications. If we do not know the frequency of our own complications, it is more difficult to correct ourselves. Is it unethical for a surgeon to reveal to a patient that a complication rate for a particular operation is very low when in fact the actual complication rate is unknown and may not be very low? And what is considered very low to that surgeon? Such terms are subjective by nature in the absence of hard data.

Self-analysis is implemented during the transparent **debriefing exercise** for all pilots after all flights. The airline industry has demonstrated that there must be a **level playing field** for all participants. Any surgeon should be amendable to correction, regardless of his or her position in the orchestra. Every musician must be aware of any member's repeated mistakes that can make a symphony less enjoyable.

The medical industry will never stop urging surgeons to *try* certain procedures that employ new devices. **The medical industry is the supplier of the instruments we play and often a muted critic when the concert does not go well.** Even when some of the instruments are defective, industry will usually accuse the surgeon "musician" of being inept, and industry lawyers will try to deflect any instrument defect. We are witnessing an equipment evolution, and patient safety should be the theme of the music. Laparoscopic cholecystectomy was an operation that many of us learned from each other, supplemented in some instances with practice on a pig. Clearly the rate of common bile duct injuries is still much higher than with open cholecystectomy, and there are constant *tips* on how to avoid pitfalls and strike the right notes at the right time. But there is no putting the genie

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back into the bottle. Minimally invasive surgery has continued to advance in spite of misadventures. It is like a hit musical and surgeons are required to perform at a Broadway level, several times a day.

With regard to the concepts mentioned in this paper, the *Statement of Principles of the American College of Surgeons*, indicates the following abstracted guidelines that are relevant:

- Performance of surgical procedures by those who are not properly trained to perform them should not be a frequent or continuing practice.
- Fellows are strongly encouraged to be actively involved as leaders of quality assessment and improvement activities in their own hospitals.
- Acquisition of skills in new procedures should be fostered by attendance at courses with both didactic and hands-on training sessions. The fellow should seek appropriate proctoring of cases as new procedures are added to his or her surgical portfolio. Continuous self-appraisal of surgical outcomes is strongly encouraged with the goal of improving patient outcomes.

We surgeons are conductors of the *concerts* and the lyrics of the American College of Surgeons fit our melodies.

References

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