Are Surgeons Ethically Obligated to Refer Patients to Other Surgeons Who Achieve Better Results?

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At the Annual Meeting of The Society of Thoracic Surgeons in January 2003, The Ethics Forum sponsored a debate on a topic of great interest to cardiothoracic surgeons. When patients who need an operation are referred to us, we feel obligated for a variety of reasons to provide surgical care to the patient. There may be times when we ought to refer a patient to a more experienced surgeon for the good of the patient, yet we rarely make such a referral.

A case was presented to provide focus for the discussion. Two of our colleagues who have long been among the leaders of cardiothoracic surgery were assigned to either the positive or negative side of the question: Are surgeons ethically obligated to refer patients to other surgeons who achieve better results? The case, the two opposing positions, and a concluding comment follow.

Case

A 23-year-old woman was recently found to have severe aortic stenosis with a small aortic root and is in need of an operation. Mrs. Barefoot was married a year ago, comes from a large family, and plans to have a large family of her own. She is a voracious reader and Internet user, and her search for information has led her to the conclusion that the best treatment for her aortic stenosis is a Ross operation. She realizes that the long-term results of that operation are unclear, but wants to avoid anticoagulation in her childbearing years.

Her cardiologist refers her to Dr. Click, a cardiothoracic surgeon at University Hospital. He examines the patient, reviews her data, and agrees that she needs an operation. He has done 13 Ross procedures with 2 deaths, a mortality rate of 15%, which compares with 2% to 3% at the heart centers with larger volumes, including Crosstown Memorial Hospital, the competing center in the same city. The aortic valve operation he does best is mechanical valve replacement with root enlargement if necessary, which he believes to be a suitable procedure for her valve problem.

Dr. Click believes that the Ross operation is better for pregnant women, although the long-term results are uncertain, and he thinks briefly about referring her elsewhere. Instead, however, he decides not to refer her but to offer her the choice of a mechanical valve replacement, which can be managed safely during pregnancy, or a Ross procedure.

Pro

Nicholas T. Kouchoukos, MD

My charge in this debate is to defend the position in the scenario described that the surgeon is obligated on ethical grounds to refer the patient who desires a Ross operation to another surgeon who has achieved better results with this procedure. My remarks relate only to the specific conditions put forth in the clinical summary. As with many ethical issues in medicine, there is no clear-cut answer to this dilemma. However, I will offer an argument in support of the supposition that the surgeon has acted unethically in this situation by offering to do the procedure himself. Let us first examine the background information.

What Does the Patient Believe and Know?

The patient believes, based up information she has gathered herself, that the Ross procedure is her best option. She knows that she does not want to take oral anticoagulants during her childbearing years. She appears to know the limitations of the procedure, including the possibility of a second operation.
What Does the Surgeon Believe and Know?

He believes that the Ross operation is preferable to a mechanical valve replacement for a woman who wishes to become pregnant. He knows that his experience with this procedure is limited and that his operative mortality is higher than that of his colleagues in his own area and elsewhere. He knows that he can perform a mechanical valve replacement with a low operative risk.

What Does the Surgeon Do?

He offers the patient the options, with himself as the operating surgeon, of either the Ross procedure or a mechanical valve replacement.

Is the surgeon acting unethically by offering the patient two options, believing that one is inferior to the other, and by not referring the patient to a more experienced surgeon?

I would answer yes. Ethical is defined in the Random House Dictionary of the English Language as (1) pertaining to or dealing with morals or the principles of morality; pertaining to right and wrong conduct; (2) in accordance with the rules or standards for right conduct or practice, especially the standards of the profession.

Why is the Surgeon Acting Unethically?

I believe he is acting unethically for several reasons: (1) He is offering the patient the option of a procedure (mechanical valve replacement), which he believes is inferior to the alternative procedure (pulmonary autograft) in her particular circumstance; (2) He is not fully abiding by the wishes of the patient to avoid anticoagulation. Although her decision to avoid anticoagulation could be questioned, it is nevertheless a valid one, because satisfactory alternatives to replacement of the aortic valve with a mechanical valve exist that do not require permanent anticoagulation; (3) He is not offering the patient the option to discuss the Ross operation with a more experienced surgeon (across town or elsewhere); (4) He is putting his self-interest (i.e., doing another operation to increase his numbers, collecting a fee, preserving his referral base, and so forth) above the best interests and welfare of the patient. Therefore, I believe that he has violated the standards of our profession (as described in definition #2 above).

What Should the Surgeon Do to Demonstrate Ethical Behavior?

I believe that he should thoroughly discuss the pros and cons of both the Ross operation and the mechanical prosthesis with the patient and also acquaint her with the other alternatives that would avoid oral anticoagulation (i.e., aortic allograft, porcine, or pericardial bioprosthesis) to be certain that she is fully aware of all the available options. He should fully describe the relative risks of the two therapeutic options that he is proposing. He should candidly discuss his personal experience and outcomes with the two procedures. He should most certainly offer the patient the option to discuss the Ross procedure with a more experienced surgeon. Most of all, he should consider the welfare of the patient as more important than his own personal interests.

There are no clearly established rules that pertain to what is right or wrong in this particular clinical situation. The surgeon must make the decision to act ethically based upon his own moral compass, a clear understanding of the implications of all therapeutic options, a critical assessment of his own abilities and limitations, and the general ethical principles of the medical profession, which include the doctrine of primum non nocere.

Con

Lawrence H. Cohn, MD

The ethical question being discussed underscores the dilemma of surgeons possessing varying degrees of skill related to a complex operation and whether or not they should refer to surgeons with greater experience. For the purposes of this debate, I have taken the con position in the following essay.

In the ideal world, the best surgeon in the world for a particular disease or condition would operate on every patient with that condition. Obviously, this is not practical or desirable. It would not be physically possible for only a few surgeons to do all of the operations of a particular type, and it would be undesirable not to disseminate knowledge of a new technique. Surgeons going through American thoracic training programs believe that they are competent enough to do most procedures that are required for the American Board of Thoracic Surgery certification, provided they have had exposure to said techniques. The chief of the cardiothoracic surgery service certifies that a trainee is technically and intellectually competent to take the American Board of Thoracic Surgery examination, which determines board certification. The American Board of Thoracic Surgery certificate indicates that this person has demonstrated cognitive and judgmental knowledge satisfactory to practice cardiothoracic surgery in all its aspects. Given the proper environment after training, most of these individuals will learn complex procedures and learn to do them well either as a trainee or as a practitioner. Surgeons who do not attempt to learn complex procedures after training will not gain the necessary training.
experience to perform the procedures safely. Thus, in this debate scenario, theoretically no one would be able to gather enough experience to do complex procedures if most of these procedures were directed to only a few surgeons, and this is the crux of the matter.

What factors in this era tend to inhibit referrals from one institution to another, or from one surgeon to another? Certainly the desire to keep the patient closer to home and in touch with their local health system in a hospital with doctors that they know and where their family has easy access is extremely attractive. From a surgeon’s point of view there are factors inhibiting referrals to other surgeons. The fee structure of cardiac surgery has fallen dramatically because of reductions in Medicare, which have occurred beginning in the late 1980s to the present. In 1988, the real dollar value reimbursement from Medicare for a triple coronary bypass (two veins, one artery) was $4,200. The same operation rate proposed for this past April, which was fortunately put on hold, was to be $1,950 with a real dollar value consumer price index inflation index of $1,250. Therefore, obviously losing cases is something that surgeons do not necessarily like to do, and in fact, most surgeons are increasing their workload to keep the same monetary value as in previous years.

For a well-trained individual who understands the procedure and has considerable operative experience around the aortic root, there is really no reason not to attempt a complex procedure, given the right patient and appropriate indications. The beginning of laparoscopic cholecystectomy in 1985 is a good example of those who would subsequently do these procedures who were obviously less experienced than the surgeon that first performed the operation. Thus the surgeon that started the procedure would obviously always have the longest experience, because no one could ever be anything but second to that individual. However, if individuals with the appropriate training and experience had not learned the operative procedure, then it would not have become widespread and therefore its usefulness would be lost.

In the clinical scenario of this debate, the patient in question would have talked to the surgeon at some point during the discussions related to valve choice, and the surgeon’s experience should have been queried by the patient. If the surgeon were to respond at that time, “I have moderate experience with this technique, some 10 to 15 patients, most who have done well,” I believe this would be reassuring to the patient. If the patient presses the questioning further, whether the surgeon has done as much as the doctor in the cross-town hospital, he must truthfully say “no,” and the patient will infer from this that the surgeon across town is more experienced. It is important to relate your actual experience when queried. In a recent litigation in another subspecialty of surgery, a very complicated operation done successfully (probably only performed by 3 practitioners in the country) was found to be necessary for a patient who presented himself to the surgeon of the subspecialty and who had asked if the surgeon had previously performed this procedure. The surgeon had only seen 1 other case in his training, and had personally never performed this procedure, yet the surgeon responded “yes” that he could do it. The patient expired postoperatively and the family sued the surgeon because there was lack of informed consent regarding the surgeon’s ability to perform this procedure. The plaintiff won.

Another factor that may inhibit referral for a Ross operation is an alternative operation, perhaps as good in this particular clinical situation. For a 23-year-old childbearing female, the scenario was that the patient should try to avoid warfarin anticoagulation when she is contemplating pregnancy. Clearly, a bi-leaflet prosthetic valve is the most durable, but it requires anticoagulation, which may lead to birth defects or bleeding problems. So what are the other less complex alternatives that a woman could contemplate instead of a Ross operation? Certainly homograft root replacement could be considered as well as a stentless porcine valve, which is less desirable, or even a stented bioprosthetic valve, which is much less desirable with the knowledge that she would need a follow-up operation at some point because of structural valve degeneration. Minimally invasive procedures can also be used for all of these operations except a Ross procedure [1]. Small incision surgery would then make a reoperation much safer and less morbid. Furthermore, the safety of many of these alternative operations is vastly different then it was 10 years ago. In a recently reported experience at the Brigham and Women’s Hospital, isolated elective homograft aortic root replacement was performed in 100 consecutive patients without mortality [2].

Finally, the Ross procedure is not a panacea. We now recognize a number of problems with this operation [3]. In patients with aortic regurgitation and a dilated aortic root, the pulmonary autograft root may become dilated after transplantation as the neo-aortic root. We know that the pulmonary homograft may form severe truncal stenosis in 10% of the patients, some of whom have to undergo reoperations. Most importantly, if we look at the wide range of results with the Ross operation, the Ross Registry mortality is approximately 2.5% [4]. A woman of this age, health status, and low risk should undergo an operation with a risk of less than 1%.

In summary, a surgeon should refer a patient to more experienced colleagues when their own experience is limited to none with a particular procedure. However, if the surgeon has had moderate exposure to the particular procedure, good personal operative experience, good training, and total familiarity with the aortic root under a variety of conditions, then it is appropriate for that surgeon to do these complex operations, such as the Ross procedure. More centers would then be capable of performing these procedures on a widespread basis. Obviously, this concept does not pertain to the areas in which there is a vast expenditure of resources and logistics, such as the total artificial heart or permanent left ventricular assist device.

If all patients requiring complex procedures were always referred elsewhere, only a few surgeons would learn new procedures, and therefore, technologic and
therapeutic advancements would not be disseminated in many parts of the country.

References

Concluding Remarks
Robert M. Sade, MD

Surgeons rarely refer patients to other surgeons, so we should not be surprised that Dr. Click did not refer Mrs. Barefoot, even though other surgeons have more experience and better results with the operation that the patient initially preferred. Should Dr. Click have referred this patient to another surgeon?

As requested, our discussants have given us two different responses to this question. Nicholas Kouchoukos answered, “Yes” and found several ethical transgressions in Dr. Click’s handling of the referral. He points to the paramount obligation of physicians to do what is best for the patient rather than to do what is in one’s own self interest. On these grounds Dr. Click should have referred Mrs. Barefoot, if only for a second opinion with the possibility that another surgeon could offer the patient a better result.

Lawrence Cohn takes the contrary view that Dr. Click was justified in not referring Mrs. Barefoot, because the standard for whether a surgeon should do a particular operation is not whether he has the largest experience or the best results, but whether he is competent to do it. The originator of a new procedure or an early disciple would nearly always have the largest experience, would be further along the learning curve, and therefore, would usually have better results than most of the surgeons who follow. Thus, says Cohn, if only the surgeons with the best results and largest experience did a particular operation, most patients would not have access to relatively new procedures because few surgeons would be doing it. It is competence, not extraordinary expertise, that a surgeon must offer his patients.

Case histories provide a useful basis for consideration of controversial issues, because they put a human face on and bring to life what otherwise may be a dry theoretical discussion. However, such brief case reports have a serious limitation; the information available is necessarily sketchy, and much of the missing information is germane to the topic. For example, Mrs. Barefoot arrives in Dr. Click’s office with a treatment preference based on publicly available information, but her views will be further developed and refined by what the surgeon tells her. How much information has Dr. Click given her? How much has he told her about surgical options other than the two he finally offered? What was her response to that information? How much has her view of anticoagulation and commitment to a Ross operation shifted? How forthcoming was he with outcome data of his own practice and of others? We don’t know the answer to any of these questions.

There is also much we do not know about Dr. Click. He believes that “the Ross operation is better for pregnant women,” but does he believe the Ross operation to be substantially better or only slightly better than the alternatives? His motivation in not referring Mrs. Barefoot is critically important in judging his actions. What is his practice environment? In his academic department, are the collections he generates only marginally related to his salary? Is his practice fiercely competitive with the more experienced surgeon in town or do they have a collegial relationship?

The answers to these and other contextual questions may very well shift our view of Dr. Click’s ethical behavior. This is why principles of ethics play an essential role in medical ethics. They provide the framework upon which concrete details of a particular case can be arranged to help make correct judgments. The principles applicable to this case have been cited by Kouchoukos and Cohn: The surgeon’s first priority is the patient’s best interest; sufficient factual information must be disclosed to patients to allow them to make informed decisions based on their own values; and surgeons should maintain competence through critical self analysis and provide competent services.

Kouchoukos and Cohn applied these principles but came to different conclusions about Dr. Click’s ethical position, in part because they made different assumptions about the content of the surgeon-patient conversation regarding surgical options and outcome probabilities. However, both of these surgeons agree that there are situations in which the ethical course for the surgeon is to refer the patient to a more experienced surgeon. Exactly how a surgeon should be able to recognize these situations is not obvious. One thing is clear: honest and uncompromising appraisal of our own capabilities is the critical requirement for making correct judgments about our own competence, both in general and for particular procedures. For surgeons, this may be the most difficult task of all.